DOCUMENT RESUME

ED 457 276	UD 034 416
AUTHOR	Polit, Denise F.; London, Andrew S.; Martinez, John M.
TITLE	The Health of Poor Urban Women: Findings from the Project on Devolution and Urban Change.
INSTITUTION	Manpower Demonstration Research Corp., New York, NY.
SPONS AGENCY	Pew Charitable Trusts, Philadelphia, PA.; Robert Wood Johnson Foundation, Princeton, NJ.; Department of Health and Human Services, Washington, DC.; John S. and James L. Knight Foundation, Miami, FL.; Joyce Foundation, Chicago, IL.; Cleveland Foundation, OH.; George Gund Foundation, Cleveland, OH.; William Penn Foundation, Philadelphia, PA.; James G. Irvine Foundation, San Francisco, CA.; California Wellness Foundation.; Edna McConnell Clark Foundation, New York, NY.; Kellogg Foundation, Battle Creek, MI.; Mott (C.S.) Foundation, Flint, MI.; Ford Foundation, New York, NY.; Ewing Marion Kauffman Foundation, Kansas City, MO.; Ambrose Monell Foundation, New York, NY.; Alcoa Foundation, Pittsburgh, PA.; Grable Foundation, Pittsburgh, PA.; New York Times Co., NY.; Open Society Inst., New York, NY.
PUB DATE	2001-05-00
NOTE	348p.; Also supported by the Anheuser-Busch, Heinz Family, and Union Carbide Foundations.
AVAILABLE FROM	Manpower Demonstration Research Corporation, 16 East 34 Street, New York, NY 10016. Tel: 212-532-3200; Web site: http://www.mdrc.org.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC14 Plus Postage.
DESCRIPTORS	Child Health; Employment; *Females; Health Behavior; Health Insurance; *Health Needs; Housing; Mental Health; Physical Health; *Poverty; *Urban Areas; *Welfare Recipients; Welfare Services; Working Poor
IDENTIFIERS	*Access to Health Care

ABSTRACT

This report examines the prevalence and severity of health problems that hinder welfare recipients' ability to get and hold jobs, using data from interviews with women who in May 1995 received welfare and lived in four poor, urban areas. The study compared the health of women who had left welfare and were working, who combined welfare and work, who received welfare and did not work, or who neither worked nor received welfare. Interviews occurred in 1998 and 1999, before anyone had reached federal time limits. These women and their children had markedly higher rates of physical and mental health problems than did national samples. Their health problems were often multiple and severe. Over 70 percent faced at least one of eight health-related barriers to work (e.g., being morbidly obese or having a child with an illness that constrained employment), and 40 percent had two or more. Working women, especially welfare leavers, were in much better health than unemployed women, but many lacked health insurance. Women with multiple health problems were more likely than other women to have been sanctioned by welfare agencies in the previous year. Unemployed welfare leavers had the most compromised health situations. (Contains 190 references.) (SM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

UD

ED 457 276

The Health of Poor Urban Women

Findings from the Project on Devolution and Urban Change

Denise F. Polit
Andrew S. London
John M. Martinez

May 2001

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

J. S. Greissman
Manpower Demonstration Research Corp.

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

UD034416

BEST COPY AVAILABLE

BOARD OF DIRECTORS

ROBERT SOLOW, *Chairman*
Institute Professor
Massachusetts Institute of Technology

RUDOLPH G. PENNER, *Treasurer*
Senior Fellow
Urban Institute

MARY JO BANE
Professor of Public Policy
John F. Kennedy School of Government
Harvard University

REBECCA M. BLANK
Dean
Gerald R. Ford School of Public Policy
University of Michigan

RON HASKINS
Senior Fellow
Brookings Institution

JAMES H. JOHNSON, JR.
E. Maynard Adams Professor of Business,
Geography, and Sociology
Director, Urban Investment Strategies Center
University of North Carolina

RICHARD J. MURNANE
Professor of Education
Graduate School of Education
Harvard University

MARION O. SANDLER
Chairman and CEO
Golden West Financial Corporation and
World Savings and Loan Association

ISABEL V. SAWHILL
Senior Fellow
Brookings Institution

LAWRENCE J. STUPSKI
Chairman
Stupski Family Foundation

WILLIAM JULIUS WILSON
Malcolm Wiener Professor of Social Policy
John F. Kennedy School of Government
Harvard University

JUDITH M. GUERON
President
Manpower Demonstration Research Corporation

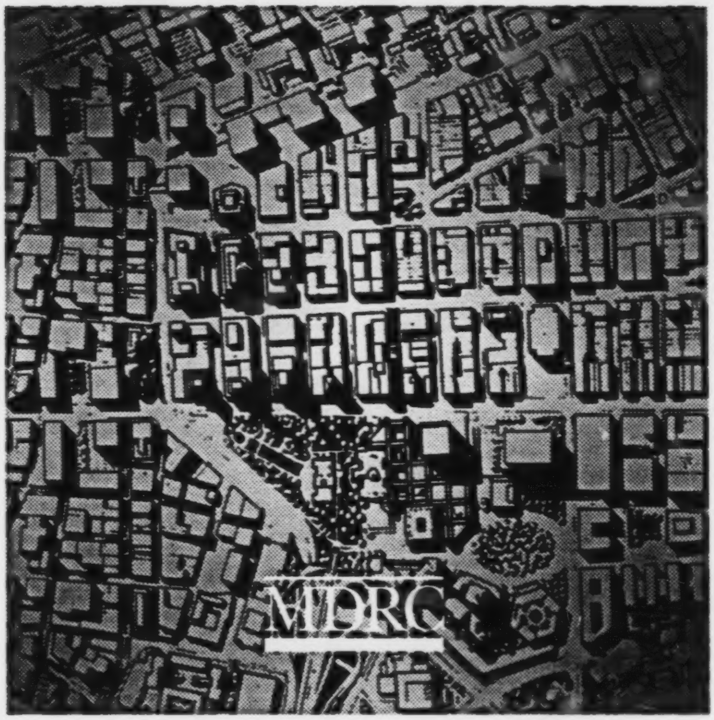
MDRC

The Health of Poor Urban Women

Findings from the Project on Devolution and Urban Change

Denise F. Polit
Andrew S. London
John M. Martinez

May 2001



Manpower Demonstration Research Corporation

Funders of the Project on Devolution and Urban Change

Ford Foundation	John S. and James L. Knight Foundation
Charles Stewart Mott Foundation	The Joyce Foundation
The Pew Charitable Trusts	The Cleveland Foundation
W. K. Kellogg Foundation	The George Gund Foundation
The Robert Wood Johnson Foundation	William Penn Foundation
U.S. Department of Health and Human Services (including interagency funds from the U.S. Department of Agriculture)	The James Irvine Foundation
	The California Wellness Foundation
	The Edna McConnell Clark Foundation

Dissemination of MDRC publications is also supported by the following foundations that help finance MDRC's public policy outreach and expanding efforts to communicate the results and implications of our work to policymakers, practitioners, and others: the Ford, Ewing Marion Kauffman, Ambrose Monell, Alcoa, George Gund, Grable, Anheuser-Busch, New York Times Company, Heinz Family, and Union Carbide Foundations; and the Open Society Institute.

The findings and conclusions in this report do not necessarily represent the official positions or policies of the funders.

For information about MDRC and copies of our publications, see our Web site: www.mdrc.org.
MDRC® is a registered trademark of the Manpower Demonstration Research Corporation.

Copyright © 2001 by the Manpower Demonstration Research Corporation. All rights reserved.

OVERVIEW

The Health of Poor Urban Women

Findings from the Project on Devolution and Urban Change

To what extent might the health of welfare recipients and their children play a role in the new welfare environment? In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), creating a five-year lifetime limit on the receipt of federal cash welfare benefits for most families. PRWORA dropped the language from prior legislation that excused welfare recipients from mandatory participation in welfare-to-work activities for health reasons. The new policy considers all recipients subject to participation requirements and time limits, except for an undefined 20 percent of each state's caseload who may be excused for "good cause." There is little information about whether the 20 percent figure is sufficient to encompass all recipients with health problems — or whether women leaving welfare will be able to secure the health care they need for themselves and their children.

This report describes the health and health care needs of welfare recipients (and former recipients) living in large urban areas, where a substantial percentage of the national welfare caseload lives. The report is based on 1998-1999 survey and ethnographic data from the Project on Devolution and Urban Change, a multi-component study designed to examine the implementation and effects of PRWORA in four urban counties: Cuyahoga (Cleveland), Los Angeles, Miami-Dade, and Philadelphia. Survey respondents were selected randomly from among the May 1995 public assistance recipients residing in high-poverty neighborhoods in each county. The report compares the health of four groups of women based on their statuses at the time of the survey: women who had left welfare and were working, women who combined welfare and work, women who received welfare and did not work, and women who neither worked nor received welfare. Ethnographic interview data, collected from welfare recipients living in selected neighborhoods in each site, complement and augment the survey findings.

Among the key findings:

- The women (and their children) had substantially higher rates of physical and mental health problems than did national samples of women and children — and their health problems were often multiple and severe.
- Women who worked (especially if they had left welfare) were in much better physical and mental health than those who did not work.
- Nevertheless, working women who had left welfare often lacked health insurance and still experienced substantial physical and mental health problems, as did their children.
- The high prevalence of health problems among women who were still receiving welfare suggests that there will be major challenges to welfare agencies as a growing number of recipients face time-limit pressures.
- Women with multiple health problems (and women who had been physically abused) were more likely than other women to have been sanctioned by the welfare agency in the previous year.
- Welfare leavers who were not employed had the most compromised health situations: They tended to have high rates of health problems, lack insurance, and experience high levels of unmet need for health care.

Women's health problems and those of their children likely constrain women's entry into the workforce and their ability to remain there. Additionally, health problems compromise women's ability to comply with participation requirements, which raises questions about current sanctioning policies. Given the health care needs identified in this study, an especially critical policy challenge is to develop mechanisms to ensure that women who leave welfare maintain health insurance.

May 2001

Contents

Overview iii
List of Tables and Figures viii
Preface xii
Acknowledgments xiii
Executive Summary ES-1

1 Introduction

I. The Urban Change Study 2
II. The Welfare Policy Context 4
III. Research Questions and Analytic Approach 10
  A. Key Research Questions and Rationale 10
  B. Data Sources and Analytic Strategy 15
IV. Structure of This Report 16

2 Overview of the Urban Change Sites and the Survey Sample

I. Description of the Urban Change Sites 17
  A. Demographic Portraits 17
  B. Welfare and Related Policies 17
  C. Health-Related Characteristics of the Sites 22
II. Description of the Urban Change Survey Sample 25
  A. Characteristics of Women in the Work/Welfare Groups 25
  B. Employment Characteristics of Women Who Worked 30
  C. Welfare-Related Characteristics of Welfare Recipients 34
  D. Characteristics of Women Neither Working nor on Welfare 37
  E. Characteristics of Children, by Mother's Work/Welfare Status 39
III. Description of the Ethnographic Sample 42

3 Material Hardships: Food Insecurity, Housing Quality, and Housing Insecurity

I. Introduction 46
II. Food and Nutrition 47
  A. Food Expenditures and Food Resources 49
  B. Food Insecurity and Hunger 53
III. Housing Quality and Housing Insecurity 61
  A. Housing Quality and Hardships 64
  B. Neighborhood Quality 70
  C. Housing Insecurity 76
IV. Overall Material Hardship 80
V. Discussion 81

4 Health Status and Health Behavior

I. Introduction 84
II. Physical Health Status 85
III. Health Behavior 92
  A. Smoking 93
  B. Weight 95
IV. Relationship Between Health Status and Measures of Material Hardships and Health Behaviors 96
V. Discussion 98

5 Mental Health

I. Introduction 100
II. Mental Health 101
III. Substance Use 108
IV. Domestic Violence 111
V. Mental Health in Relation to Material Hardship and Physical Health 117
VI. Discussion 121

6 Access to Health Care and Health Services Utilization

I. Introduction 122
II. Respondent's Access to Health Care 123
  A. Respondent's Health Insurance Coverage 125
  B. Respondent's Usual Source of Health Care 134
  C. Family's Access to Health Care 139
III. Respondent's Utilization of Health Care in the Prior Year 142
IV. Unmet Needs for Health Care 146
  A. Respondent's Unmet Need for Access to and Utilization of Health Care 148
  B. Family's Unmet Need for Medical and Dental Care 148
V. Relationship Between Families' Unmet Needs and Selected Women's Health Outcomes 149
VI. Discussion 153

7 Children's Health Outcomes

I. Introduction 155
II. Children's Health Status 156
III. Children's Health Insurance 163
IV. Children's Health Care Utilization 167
V. Children's Health and Health Insurance 170
VI. Discussion 172

8 Multiple Health and Nonhealth Problems

I. Multiple Barriers to Employment 174
  A. Multiple Barriers in the Overall Urban Change Sample 174
  B. Multiple Barriers in the Four Work/Welfare Groups 179
II. Employment Enablers in the Face of Multiple Health Problems 182
III. Health Barriers and the Work and Welfare Experience 183
  A. The Employment Experience in Relation to Health Barriers 183
  B. The Welfare Experience in Relation to Health Barriers 185

9 Reflections and Implications

I. Introduction 191
II. Summary of Key Findings 192
  A. Health in the Urban Change Population 192
  B. Health in the Four Work/Welfare Groups 195
III. The Link Between Health and Employment 197
IV. Mothers and Their Children 201
V. Implications of the Findings 202
  A. Transitions Off Welfare 202
  B. Implications for Welfare Policies and Programs 203
  C. Implications for Other Policies and Programs 211
VI. Conclusion 214

Appendices

A Response Rates and Response Bias in the Urban Change Survey Sample 215
B Defining the Four Work/Welfare Research Groups 220
C Site Differences in Sample Characteristics and Health Outcomes 226
D Ever-Receivers and Never-Receivers of Welfare in the Urban Change Sample 243
E Regression Tables for Selected Health Outcomes 249
F Item Frequencies for Three Health-Related Scales 261

References 266
Recent Publications on MDRC Projects 284

List of Tables and Figures

Table		Page
1	Key Features of the Urban Change Project	ES-8
2	Comparison of Outcomes on Selected Indicators for Urban Change Respondent Survey Sample and National Samples	ES-9
3	Selected Health Status Outcomes, by Mother's Work and Welfare Status	ES-14
4	Selected Outcomes Relating to Health Care Access and Food Stamp Benefits, by Mother's Work and Welfare Status	ES-18
1.1	Key Features of the Urban Change Project	3
1.2	Key Features of the Urban Change Respondent Survey	5
1.3	Key Features of the Urban Change Ethnographic Design	6
2.1	Selected Characteristics of Welfare Reform Initiatives and CHIP Programs in Effect in 1998-1999 in the Four Urban Change Sites	19
2.2	Selected Information on Caseloads of States and Counties in the Urban Change Project	23
2.3	Selected Health Care Characteristics of the Four Urban Change Sites, Countywide and Urban Change Survey Census Tracts	24
2.4	Selected Characteristics of the Urban Change Respondent Survey Sample, 1998-1999, by Work and Welfare Status	28
2.5	Employment-Related Characteristics of Women Who Were Working at the Time of the Interview, by Welfare Receipt	31
2.6	Welfare-Related Characteristics of Women Who Were Receiving Welfare at the Time of the Interview, by Employment Status	35
2.7	Income Sources of Women Neither Working nor on Welfare at the Time of the Interview, by Current Marital Status	38
2.8	Selected Characteristics of the Focal Children in the Urban Change Respondent Survey Sample, 1998-1999, by Mothers' Work and Welfare Status	40
2.9	Characteristics of the Urban Change Ethnographic Sample, by Site	43
3.1	Food Expenses and Resources, by Work and Welfare Status	50
3.2	Food Security and Child Hunger, by Work and Welfare Status	55
3.3	Food Security, by Receipt of Food Assistance in Prior Month	57
3.4	Housing Hardship, by Work and Welfare Status	65
3.5	Neighborhood Characteristics, by Work and Welfare Status	71

10

Table		Page
3.6	Housing Insecurity, by Work and Welfare Status	77
3.7	Overall Material Hardship, by Work and Welfare Status	82
4.1	Health Status of Respondents, by Work and Welfare Status	87
4.2	Health Behavior of Survey Respondents, by Work and Welfare Status	94
4.3	Selected Material Hardship and Health Behavior Outcomes, by Self-Reported Health Status	97
5.1	Mental and Emotional Health Indicators, by Work and Welfare Status	103
5.2	Self-Reported Substance Use in Past Month, by Work and Welfare Status	110
5.3	Domestic Violence in Past Year, by Work and Welfare Status	114
5.4	Selected Material Hardship and Health Outcomes, by Risk of Depression	118
6.1	Selected Health Insurance Outcomes, by Work and Welfare Status	127
6.2	Health Insurance Status in Prior Month, by Welfare History Subgroups	131
6.3	Usual Source of Health Care, by Work and Welfare Status	136
6.4	Family-Level Access to Health Care, by Work and Welfare Status	140
6.5	Health Care Utilization and Satisfaction, by Work and Welfare Status	143
6.6	Unmet Need for Health Care, by Work and Welfare Status	14[illegible]
6.7	Selected Material Hardship and Health Outcomes, by Unmet Need for Medical or Dental Care	151
7.1	Children's Health Status and Health Risk Behaviors, by Mother's Work and Welfare Status	157
7.2	Children's Health Insurance Status, by Mother's Work and Welfare Status	165
7.3	Children's Health Care Utilization, by Mother's Work and Welfare Status	169
7.4	Selected Health Outcomes for Focal Children, by Health Insurance Status in Prior Month	171
8.1	Prevalence of Health and Nonhealth Barriers to Employment	176
8.2	Multiple Potential Barriers to Employment, by Work and Welfare Status	180
8.3	Employment Enablers Among Women with Multiple Health Problems, by Work and Welfare Status	184
8.4	Employment-Related Characteristics of Employed Women, by Number of Health Barriers	186
8.5	Welfare-Related Experiences of Welfare Leavers, by Number of Health Barriers	188

Table		Page
8.6	Welfare-Related Experiences of Current Welfare Recipients, by Number of Heath Barriers	189
9.1	Comparison of Outcomes on Selected Indicators for Urban Change Respondent Survey Sample and National Samples	193
B.1	Selected Health Outcomes, by Work and Welfare Groups Defined Three Ways	223
C.1	Selected Characteristics of the Urban Change Respondent Survey Sample, 1998-1999, by Site	227
C.2	Selected Material Hardship, by Site	230
C.3	Selected Health Status and Health Behavior Outcomes, by Site	232
C.4	Selected Mental Health Outcomes, by Site	233
C.5	Selected Health Insurance and Health Care Expenditure Outcomes, by Site	235
C.6	Selected Children's Health Outcomes, by Site	237
C.7	Health and Nonhealth Barriers, by Site	239
C.8	Selected Health Outcomes, by Site and Mother's Work and Welfare Status	240
D.1	Selected Background Characteristics of Ever-Receivers and Never-Receivers of Cash Welfare Benefits in the Urban Change Respondent Survey Sample	244
D.2	Selected Health-Related Outcomes of Ever-Receivers and Never-Receivers of Cash Welfare Benefits in the Urban Change Respondent Survey Sample	245
E.1	Estimated Regression Coefficients for Material Hardship Outcomes	250
E.2	Estimated Regression Coefficients for Physical Health Outcomes	252
E.3	Estimated Regression Coefficients for Mental Health Outcomes	254
E.4	Estimated Regression Coefficients for Health Insurance Outcomes	256
E.5	Estimated Regression Coefficients for Health Care Access/Utilization Outcomes	257
E.6	Estimated Regression Coefficients for Children's Health Care Access/Utilization Outcomes	259
F.1	Household Food Security Scale, Item Frequencies	262
F.2	Individual Item Responses for SF-12	263

Figure		Page
1	Health and Nonhealth Barriers to Employment	ES-12
2	Health Barriers to Employment	ES-15
3	Health Insurance Coverage	ES-19
1.1	Heuristic Model of Health Outcomes in This Report	14
2.1	Work/Welfare Status, by Site	26
4.1	Self-Reported Health Status, by Work and Welfare Status and in U.S. Population	88
4.2	Score on Physical Component of SF-12, by Work and Welfare Status and in U.S. Population	90
5.1	Score on Mental Component of SF-12, by Work and Welfare Status and in U.S. Population	104
6.1	Health Insurance Coverage in the Prior Month, by Work and Welfare Status and in U.S. Population	128
6.2	Location of Usual Source of Health Care, by Work and Welfare Status and in U.S. Population	138
8.1	Prevalence of Health Barriers, Urban Change Respondent Survey Sample	178
A.1	Urban Change Respondent Survey Sample Disposition	216

Preface

The Project on Devolution and Urban Change is a multidisciplinary, longitudinal study of the aftermath of the landmark 1996 federal welfare law in four large urban counties and their major cities — Cleveland, Los Angeles, Miami, and Philadelphia. This report focuses on issues critical to the long-term success of welfare reform: the physical and mental health and health care needs of welfare recipients and their children. Health concerns, which are broadly defined in this report to include health-relevant hardships such as hunger and unsafe housing, are examined in relation to people's welfare and employment status.

Prior to passage of the 1996 law, welfare recipients who had health problems or who were caring for children with health problems were not required to participate in welfare-to-work activities. Under the law, which includes a five-year limit on most families' receipt of federal cash welfare assistance, all recipients are required to participate except for an undefined 20 percent of each state's caseload.

Although it is not known how many women might warrant such exemptions on health grounds, the report's findings, which are based on a survey of nearly 4,000 women in these four large cities and in-depth ethnographic interviews with about 170 women, suggest that health problems are quite prevalent and often severe. Among the women remaining on welfare at the time of the survey in 1998-1999, nearly 80 percent had at least one health problem that could pose a challenge to employment, and about 50 percent had multiple health barriers. These health problems — which were typically accompanied by other barriers such as lack of education credentials and limited prior work experience — appeared also to affect the women's ability to comply with participation requirements. The greater the number of health problems, the greater the likelihood a woman had been sanctioned by the welfare agency for noncompliance.

Although the women who had left welfare and were working had far fewer health problems than those remaining on the rolls, they were substantially more likely to have health problems than same-age women nationally. Most were in low-wage jobs without fringe benefits, and a sizable percentage were uninsured and had children who lacked health insurance.

When policymakers debate reauthorization of key provisions of the 1996 law, we hope that the information presented in this report proves useful in deliberations over health status, in relation especially to time limits, and that these officials consider policies to ensure that women who leave welfare for work do not lose ground by losing their highly valued health benefits.

Judith M. Gueron
President

Acknowledgments

This report would not have been possible without the generous support of the funders of the Urban Change project, which are listed at the front. In addition, a number of staff members at these organizations provided useful comments, including Lawrence Wolf of the Administration for Children and Families, U.S. Department of Health and Human Services; Elizabeth Lower-Basch, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; Margaret Andrews, Craig Gundersen, Mark Nord, Laura Tiehen, and Josh Winicki of the Economic Research Service, U.S. Department of Agriculture; Gary Bickel of the Food and Nutrition Service, U.S. Department of Agriculture; and Karil Bialostosky of the National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Administrators and staff from each of the sites also provided important feedback, including Sandra Bizzel, Sherri Heller, Jennifer Lange, Michael Lichter, Marlene Shapiro, and Don Jose Stovall.

Two very capable reviewers — Linda Aiken of the University of Pennsylvania School of Nursing, and Leith Mullings of the City University of New York Graduate Center, Department of Anthropology — drew on their expertise in health issues to provide valuable comments on the final draft.

The local ethnographic teams conducted the interviews and provided the data that made it possible to better understand the success and struggles of the women in the study. We would especially like to acknowledge the team leader (and lead ethnographer for the Philadelphia site), Kathryn Edin, and the lead ethnographer from the other three Urban Change sites — Ellen Scott, co-leader with Andrew London in Cleveland, Abel Valenzuela in Los Angeles, and Alex Stepick and Stan Bowie in Miami. We would also like to acknowledge the efforts of Carol Stepick in Miami.

We are grateful to the many members of the local ethnographic teams who helped collect and code the data and would like especially to thank those who helped with preliminary analysis of the data: Gretchen Baumhover, Heather Best, Susan Clampet-Lundquist, Tasheika Hinson Coleman, Julie Diaz, Erika Garcia, Rebecca Joyce Kissane, Mirella Landriscina, Nancy Myers, and Carrie Quinlan.

The survey interviews were capably managed at Temple University's Institute for Survey Research. Karl Landis, Fred Licari, Carolyn Rahe, and Ann Shinefeld played particularly important roles. Greg Hoerz at MDRC helped to coordinate the survey work.

At MDRC, Gordon Berlin and Barbara Goldman, co-directors of the Urban Change project, provided support, guidance, and helpful comments throughout the development of the report. Judith Gueron, Thomas Brock, Charles Michalopoulos, and Nandita Verma offered valuable feedback at various stages. We are also grateful for the insights of other members of the Urban Change team. Vanessa Hosein skillfully processed and analyzed much of the data presented in this report. Rebecca Widom also contributed to the data analysis. Herbert Collado ably coordinated the report production process. Christine Barrow provided further important research assis-

tant support. Robert Weber edited the report, and Stephanie Cowell word-processed the final document.

Of course, none of this would have been possible without the cooperation of the women who are participating in the Urban Change study. We are grateful to all of them.

The Authors

Executive Summary

I. Introduction

This report addresses a timely and important question in this era of unprecedented change for poor mother-headed families:

> *What are the health situations of welfare recipients and former recipients living in large urban areas during this era of welfare reform?*

Prior studies have shown that poor people in general and welfare recipients in particular are less healthy than people who are not poor. However, *current* information is needed about the scope and intensity of health problems of welfare recipients — and recent welfare leavers — because of dramatic changes in the policies affecting them as a result of the passage in August 1996 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). One of the key features of this act is that it places a five-year lifetime limit on federally funded cash benefits for the majority of recipient families. Another important feature of PRWORA is that states now must either engage most of their caseloads in work-related activity or face financial penalties. As a result, welfare agencies must now work programmatically with women who had previously been exempted from any welfare-to-work participation requirements — including women with health problems. Thus, there is considerable interest in understanding how health and health-related issues such as domestic violence constrain recipients' ability to comply with welfare requirements and to secure stable jobs before they reach the time limit for cash assistance.

Using unusually rich and extensive data from multiple sources, this report describes the health and well-being of urban women who either had been welfare recipients or were still recipients and who, therefore, were at especially high risk of being affected by welfare reform policies. As a cautionary note, it is important to recognize that the data for this report were collected before time limits were imposed. Thus, the findings do not offer evidence on how welfare reform might affect health outcomes or on how health factors might influence the success of welfare reform. Rather, the findings provide an early snapshot of a vulnerable group of families potentially facing time-limit pressures and the loss of benefits that can affect their health and well-being.

This report is based on data from the Project on Devolution and Urban Change (Urban Change, for short), which is being undertaken by the Manpower Demonstration Research Corporation (MDRC), a nonprofit, nonpartisan organization that develops and evaluates interventions designed to improve the well-being and self-sufficiency of economically disadvantaged populations. The Urban Change project, a multicomponent study designed to examine the implementation and effects of PRWORA, is being conducted in four large urban counties: Cuyahoga, Ohio (Cleveland); Los Angeles, California; Miami-Dade, Florida; and Philadelphia, Pennsylvania.[1]

Information in this report about broadly defined health and health-care outcomes of current or former welfare recipients came from in-home survey interviews with 3,771 women and in-depth ethnographic interviews with 171 women. The ethnographic interviews were conducted in 1998 with a sample of about 30 to 40 recipients living in three high-poverty neighborhoods in each city. The survey interviews were conducted in 1998-1999 with a sample of women who, in May 1995, had been single mothers receiving benefits and living in neighborhoods of concentrated poverty; this sample was randomly selected from administrative welfare agency records. Thus, the survey findings are not based on a representative sample of all recipients but, rather, on a representative sample from very poor urban neighborhoods in four major cities with large welfare caseloads.

---

[1] For brevity's sake, the sites (that is, the counties) are often referred to in this report by the names of their principal cities: Cleveland, Los Angeles, Miami, and Philadelphia. Only in the case of Philadelphia, however, are the city and county identical in their boundaries.

In addition to providing an overall description of health outcomes in these poor, mother-headed urban families, this report for the first time examines health in four important subgroups defined on the basis of the women's employment and welfare status at the time of the survey interview. The four work/welfare subgroups are

- women who had left welfare and were working (the work-only group)
- women who were combining work with welfare (the work-and-welfare group)
- women who were receiving welfare and did not work (the welfare-only group)
- women who had left welfare and were not working (the no-work, no-welfare group)

Each of these groups poses distinct challenges to policymakers and welfare staff in relation to both safety net services and strategies for leaving and remaining off welfare in a time-limited environment. Recipients' health concerns need to be taken into consideration with regard to both policy areas.

II. The Findings in Brief

- **Compared with national samples, women in the Urban Change survey sample had *substantially* higher rates of personal health and mental health problems and children's health problems.** Women in the survey sample were more likely than women in national samples to be food insecure and hungry, to be in poor physical and emotional health, to be overweight, to have had numerous doctor visits in the prior year, and to have children in fair or poor health. On a scale indicating the number of potential health barriers to employment (out of eight specific health problems), three out of four women in the survey sample had at least one such barrier, and 40 percent had two or more health problems.

- **The ethnographic data suggest that the survey data do not fully capture the *severity* of the health-related hardships the families faced.** While the survey data provide information about the prevalence and breadth of health problems among urban welfare recipients, they do not fully capture the gravity of the women's health-related problems, or those of their children. For example, about 20 percent of the current welfare recipients in the survey sample indicated that they had one or more child with a health problem, while the ethnographic interviews provide rich, detailed accounts of the types and severity of problems the children faced, including cancer, HIV infection, cardiac problems, and mental illness.

- **Health problems were strongly related to the women's employment status.** Overall, women who were working — especially if they had already left welfare — were in substantially better physical and mental health than women who did not work, and they were also less likely to have children with health problems. Nonworking women were also much more likely than working women to have *multiple* health problems. The evidence suggests that the relationship between health and employment primarily reflects the effect that health problems had on the women's work status, and not vice versa.

- **Health care access, however, was strongly related to the women's welfare status.** Women who had left welfare — whether they were working or not — were significantly more likely than women still on welfare to have health care access problems, including not having health insurance, not having a regular health care provider, and having had a need for health or dental care that had gone unmet because of financial constraints. Women who had left welfare were also less likely to be getting food stamps, despite the fact that the large majority appeared to still be eligible for food stamp benefits.

- **The four work/welfare groups, then, had appreciably different health profiles — and all four groups had distinct health-related vulnerabilities.** Women who had exited welfare and were not working had the most compromised health situations: They had a very high rate of health problems *and* the worst health care access circumstances. Women who had left welfare and were employed were the healthiest group, but they also had health care access problems; moreover, despite their *relative* good health in comparison with women in the other three groups, many employed welfare leavers also experienced personal and children's health problems that could affect their ability to remain self-sufficient.

- **Both groups of women still on welfare, especially those without paid employment, had a high prevalence of health problems that pose challenges to welfare agencies.** The Urban Change survey data indicate that most welfare recipients — the majority of whom were subject to the welfare agency's participation requirements and the time limits for cash receipt — experienced one health problem or more. Among women in the sample who in 1998-1999 were still welfare recipients, the percentage with health problems appears to far exceed the 20 percent who might be eligible for an exemption from the federal time limits. For example, nearly 30 percent said they had a health condition that limited their ability to work; about 50 percent had two or more health barriers to employment. Yet only 14 percent of current recipients indicated that they were exempt from participation requirements because of a health problem.

- **Negative experiences with the welfare agency were more prevalent among**

women with health problems. Welfare recipients with multiple health problems and with certain health problems (notably, physical abuse, risk of depression, having a chronically ill or disabled child) were more likely than other recipients to have been sanctioned in the prior year. Welfare leavers with multiple health problems were more likely than other women who had left welfare to say that they had been terminated by the welfare agency rather than that they left of their own accord.

III. The Welfare Policy Context

In the long-standing welfare policy debate about who is or is not deserving of public support, health status has always been one consideration. Reflecting this, the Social Security Act of 1935 provided federal funds for state welfare programs covering two groups of people who were not expected to work: first, the aged, blind, and disabled (who received Supplemental Security Income, or SSI benefits); and second, single mothers, who became eligible for public welfare assistance because society saw an explicit value in providing for the care of needy children in their own homes, by their mothers. In the subsequent 65 years, however, the growth of the welfare rolls, changes in the demography of the welfare population, and the increasing movement of women (including mothers with very young children) into the labor force have eroded the legitimacy of defining welfare as an alternative to work. Accordingly, starting with the Work Incentive Program (WIN) in 1971, Congress has defined an ever-expanding group of single mothers on welfare as employable and subject to participation and work requirements, with the key exceptions being tied, until recently, to the age of the youngest child and the health of the mother or her children. For example, prior to the passage of PRWORA in 1996, women with children under age 3 (or under age 1, at the option of the state), or who were *ill or incapacitated or taking care of a household member who was ill or incapacitated,* could not be required to participate in welfare-to-work programs.

The 1996 PRWORA legislation took one further step in this evolution by dropping the language that excuses people from mandatory participation for health reasons. Participation requirements and time limits now extend to the full welfare caseload. Excluding those who meet the stringent SSI disability definition, the new policy defines all welfare recipients as employable, with the exception of an undefined 20 percent who may be excused from the federal time limits for "good cause."

PRWORA introduced a number of other changes as well. It replaced the previous cash welfare program (Aid to Families with Dependent Children, or AFDC) with a new form of aid called Temporary Assistance for Needy Families (TANF). The act provides lump-sum block grants to states and gives them unprecedented discretion and responsibility for developing welfare programs. However, PRWORA involves certain federal mandates, notably, a five-year lifetime limit on federally assisted cash benefits for most families. States may grant exemptions from the federal time limit, but the number of exempted families may not exceed 20 percent of the average monthly caseload in the state (although states can use their own funds to support families after the five-year limit). PRWORA also imposes more stringent work and participation requirements than had previously existed, requiring most recipients to go to work no later than two years after becoming eligible for TANF benefits. Thus, an implicit assumption of PRWORA is that the great majority of recipients are sufficiently healthy and employment-ready to participate in mandated work-related activities and, eventually, to become self-sufficient through employment.

Under PRWORA, states have great latitude in designing their own welfare policies and programs, as well as certain policies relating to food stamps and medical assistance — benefits that have clear health implications. For example, states make decisions regarding the criteria for exemptions from or extensions of the time limits; receipt of transitional services such as child care and medical assistance after welfare exit; and eligibility criteria for Medicaid. In addition, states can place even more stringent time limits on clients' receipt of cash aid than the five-year limit mandated by the federal legislation. As a consequence, each state now runs its own individualized welfare program. Recipients in the four sites selected for the Urban Change project are subject to substantially different rules, procedures, and programs.[2] All the states, however, face one new challenge in common: They are now required under the PRWORA provisions to work with many recipients who previously would have been granted exemptions — including those with health, mental health, domestic violence, and substance abuse problems.

Thus far, there have been some encouraging early signs about certain aspects of welfare reform. In particular, despite the fact that the five-year federal time limit has not yet been reached by those who were receiving benefits when the legislation was enacted in 1996, the welfare rolls have dropped sharply, both nationally and in all four states involved in the Urban Change study. While time-limit terminations have not yet directly reduced the caseloads in most states, the current emphases on work and time limits have apparently led many to leave (or not apply for) welfare. However, many factors besides welfare reform have undoubtedly contributed to caseload declines, including the strong economy and greater availability of jobs and the expansion of the Earned Income Tax Credit (EITC), which is a special tax credit primarily benefiting low-income working parents.

Whatever the underlying causes, the rapidly declining welfare caseloads have prompted considerable concern about recipients who have remained on the rolls during this era of economic prosperity — in particular, about the barriers they face to employment and about possible strategies for moving them into the labor force. At the same time, there is interest in the fate of recipients who have left welfare — how well they are managing, how stable their employment situations are, and how successful they have been in accessing services that support their transition to employment. Of particular interest is access to two key safety net programs that are relevant to the health of poor families: food stamps and medical assistance.

Despite the fact that the Food Stamp Program was scaled back through several PRWORA provisions, food stamp benefits have continued as one of the few federal entitlement programs and are considered a cornerstone of aid to the working poor. During the 1994-1999 period, however, participation in the Food Stamp Program declined by 33 percent, a larger reduction than can be attributed to the improved economy or welfare reform. There is emerging evidence that growing numbers of eligible families are no longer receiving food stamps, giving rise to some apprehension about the nutritional status of poor families leaving welfare.

---

[2] The early implementation experiences of welfare agencies in the four Urban Change sites are described in an earlier report. See Janet Quint, Kathryn Edin, Maria Buck, Barbara Fink, Yolanda Padilla, Olis Simmons-Hewitt, and Mary Valmont, *Big Cities and Welfare Reform: Early Implementation and Ethnographic Findings from the Project on Devolution and Urban Change* (New York: MDRC, 1999).

Similar concerns exist with regard to health insurance. Until the passage of PRWORA, cash assistance and Medicaid (the federal program providing health insurance to the poor) were linked. However, in recognition of the fact that most women who leave welfare for low-wage jobs do not get employer-provided health insurance, Congress tried to minimize adverse effects of welfare reform on health care coverage by severing the ties between Medicaid eligibility and eligibility for TANF. States are now required to provide Medicaid coverage to families who meet income and family structure guidelines that applied to the AFDC program on July 16, 1996, even if those families do not meet their state's new cash assistance criteria. Thus, there is no time limit for Medicaid benefits, but wage-earners qualify only if their incomes are very low. (States also offer transitional Medicaid benefits to workers leaving welfare, regardless of their earnings, for periods of 6 to 12 months, depending on the state.) Additionally, in 1997 Congress passed a major health care expansion, the Children's Health Insurance Program (CHIP), a voluntary matching program that allows states to expand health insurance for uninsured children in low-income families. However, as is the case with food stamps, many children and their parents who are eligible for Medicaid and CHIP coverage appear not to have enrolled. In 1996, for the first time in about a decade, the number of people insured by Medicaid declined, while the rate of uninsured people nationally increased, leading to speculation that an unintended consequence of welfare reform is the loss of health care insurance for many low-income families.[3]

Thus, a number of recent policy changes that have the potential to affect poor families' access to food stamps, Medicaid, and cash assistance could, in turn, have implications for their health and health care access. At the same time, health-related issues have implications for the success of the new policies.

IV. The Urban Change Project

The Urban Change project is one of several studies that are examining the implementation and effects of PRWORA. The Urban Change project is distinctive in a number of respects and is expected to yield data of unparalleled breadth and depth that can be used to address many questions of relevance to policymakers and practitioners.

One distinctive aspect of the Urban Change project is its urban focus, which was based on the assumption that the effects of welfare reform — favorable or unfavorable — will be most evident in urban areas, where poverty and welfare receipt (and public health problems) are concentrated. Indeed, the majority of welfare recipients in the United States live in urban areas; nearly one-third (32.7 percent) of all welfare recipients in 1999 lived in 10 of the largest urban counties — three of which are Urban Change sites: Cuyahoga (Cleveland), Los Angeles, and Philadelphia. In fact, some 14 percent of all welfare recipients in the United States lived in the four Urban Change counties in 1999, and that percentage has been growing.

---

[3] There is some very recent evidence that this situation is improving, as described in Janet Quint and Rebecca Widom, *Post-TANF Food Stamp and Medicaid Benefits: Factors That Aid or Impede Their Receipt* (New York: MDRC, 2000). However, initiatives to prevent eligible families from losing Medicaid benefits upon welfare exit were not in place when the 1998-1999 survey data for the present report were collected.

A second noteworthy aspect of the Urban Change project is its multidisciplinary nature. The study involves five distinctive components that are designed to complement each other. Data from these components will be carefully integrated to provide rich, comprehensive descriptions of the welfare reform stories that are unfolding in the four Urban Change sites. Table 1 summarizes the major features of the five Urban Change study components. A third unique characteristic of Urban Change can be seen in this table: The study has the potential to answer questions about welfare reform at different levels of aggregation, and from different perspectives. The project will analyze and integrate multicomponent data to answer questions about PRWORA in relation to individual recipients, their children, the neighborhoods in which they live, and the welfare agencies and other providers that serve them.

The current report uses first-round data from the survey and ethnographic components of the Urban Change project, collected in 1998-1999 — after PRWORA was implemented but before any time limits were imposed. The report focuses on describing the health-related living conditions, physical and mental health statuses, and health care access of women who were at different points in the hoped-for trajectory between welfare receipt and self-sufficiency, and it addresses questions about the extent to which that expected trajectory is consistent with the life circumstances of the recipients.

V. The Prevalence and Complexity of Health Problems in the Urban Change Population

The women in the Urban Change samples, as a whole, had a large number of health problems — problems that have implications for the women's employability and for their ability to comply with welfare participation requirements.

- **Women in both the survey and the ethnographic samples were substantially less healthy and had greater health care access problems than national samples of adults.**

Consistent with the fact that women in Urban Change samples were economically disadvantaged, health problems and health-relevant hardships abounded. As shown in Table 2, the women in the Urban Change survey sample were more likely than national samples of adults to be food insecure, to have severe housing problems, to be in fair or poor health, to have unfavorable scores on a widely used measure of physical and mental health, to be overweight, to smoke, and to have had numerous doctor visits in the prior year. Moreover, despite the fact that more than half these women were still on welfare, the sample as a whole had higher rates of being uninsured than national samples. Finally, the women were more likely to have children who had experienced hunger and who were in fair or poor health. For several health measures, the Urban Change sample had even worse outcomes than national samples of disadvantaged groups, such as people who had incomes below poverty or who had not completed high school (not shown in table).

The Project on Devolution and Urban Change

Table 1

Key Features of the Urban Change Project

Goal
To understand how state and local welfare agencies, poor neighborhoods, and low-income families are affected by the changes to the income support system in response to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

Locations (sites)
Four large urban counties: Cuyahoga (Cleveland, Ohio), Los Angeles, Miami-Dade, and Philadelphia

Time frame
1997–2002

Project components
The *Ethnographic Study* illuminates the effects of the changes by chronicling, in depth and over time, how approximately 40 welfare-reliant families in each site cope with the new rules and policies.

The *Implementation Study* describes both the new welfare initiatives — rules, messages, benefits, and services — that are developed at the state and local levels and the experiences of the local welfare agencies in putting these new initiatives into practice.

The *Individual-Level Impact Study* measures the impact of the new policies on welfare, employment, earnings, and other indicators of individual and family well-being, via two components:

1. an *administrative records component*, for countywide samples of welfare recipients and other poor people
2. a *survey component* involving two waves of in-person interviews with a sample of residents of high-poverty neighborhoods

The *Institutional Study* examines how the new policies and funding mechanisms affect nonprofit institutions and neighborhood businesses.

The *Neighborhood Indicators Study* assesses changes in statistical indicators that reflect the social and economic vitality of urban counties and of neighborhoods within them where poverty and welfare receipt are concentrated.

Distinctive features
Its urban focus. The project examines the impacts of welfare reform in America's big cities.

Its neighborhood focus. All five components of the project will focus especially on residents of high-poverty neighborhoods, the public and nonprofit agencies that assist them, and the effects of welfare reform on the stability and vitality of their communities. Findings will also be reported at the county level.

Its effort to integrate findings across the components. The goal of the project is to bring multiple data sources and methodologies to bear in answering the questions of interest. The results of the separate studies are intended to illuminate, clarify, reinforce, and otherwise complement each other, as exemplified in this report.

The Project on Devolution and Urban Change

Table 2

Comparison of Outcomes on Selected Indicators for Urban Change Respondent Survey Sample and National Samples

Outcome	Urban Change Sample	National Sample	National Comparison Group
Food insecure[a] (%)	49	10	All families[b]
		36	All families below poverty
Childhood hunger (%)	5	1	All families with children
Worst-case housing needs[c] (%)	34	7	All families
Reports fair to poor health (%)	25	8	Women age 25-44[d]
		12	Black women age 25-44
Low score on a standardized physical health scale (SF-12)[e] (%)	31	10	Adults age 18-44
Low score on a standardized mental health scale (SF-12)[e] (%)	26	16	Adults age 18-44
Currently smokes cigarettes (%)	40	23	Women over 18[d]
Overweight (BMI greater than 25)[f] (%)	66	37	Women age 20-34[d]
		50	Women age 35-44
Average number of doctor visits, past 12 months	6.0	5.4	Women age 18-44
Preschool-age child in fair to poor health (%)	8	3	Children under age 6
Adolescent child in fair to poor health (%)	12	3	Children age 5-17

(continued)

Table 2 (continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[b] 1998 Current Population Survey; in G. Bickel, S. Carlson, and M. Nord, Household food security in the United States, 1995-1998 (Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service, 1999).

[c] Families have worst-case housing needs if they have no rental assistance and pay more than 50 percent of their income (not including food stamps) for rent and utilities.

[d] 1996 National Health Interview Survey, National Center for Health Statistics, Current estimates from the National Health Interview Survey, 1996, *Vital and Health Statistics*, Series 10, No. 200 (Washington, DC: U.S. Department of Health and Human Services, 1999).

[e] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[f] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

- **For the Urban Change sample as a whole, *multiple* health problems were the rule, not the exception.**

On a scale indicating the number of potential health barriers to employment, only 26 percent of the survey sample had none of the eight health problems included,[4] whereas *more than 40 percent had multiple health problems*. Moreover, the health problems of these women were typically compounded by other constraints that would presumably pose additional challenges to finding and keeping a job — constraints that have traditionally been the focus of discussions about welfare recipients' employability: having no work experience, not having a high school diploma, not speaking English, and having many or very young children. When these five non-health-related constraints to employment were added to the multiple health barrier scale, *less than 10 percent of the sample faced* none *of the 13 constraints,* as shown in Figure 1. Fully three times as many women had four barriers or more as had none (29.6 percent versus 9.1 percent, respectively), and roughly half the sample had at least three barriers.

- **The survey provides descriptions of the prevalence and scope of health problems among women in Urban Change, but the ethnographic data more fully capture the *severity* and complexity of the health-related hardships the families faced.**

The ethnographic interviews yield rich, in-depth, and dynamic glimpses into the lives of women living in selected neighborhoods in the Urban Change sites. Their stories provide insights into the gravity of health problems in this population of poor urban women and reveal that chronic illness, disability, injury, and health risks among families still receiving welfare created burdens from which few were totally exempt. The ethnographic interviews not only confirm the prevalence and salience of health problems reported in the survey but also suggest that the survey findings may to some extent lead to *underestimates* of their health problems. For example, about half the women in the ethnographic sample, as in the survey sample, were food insecure. However, the ethnographic data reveal that *even women who were rated as food secure* needed to piece together a complex array of tactics (eating day-old bread, using food pantries, getting food donations from family members) to ensure that their food needs were satisfied. As another example, women in the ethnographic sample often responded to direct questions about their physical health by saying it was "good," while in the context of other discussions they volunteered information about serious and sometimes multiple health problems. Additionally, the ethnography reveals that when mothers indicated that their children had health problems, these problems were often quite severe. The ethnographic sample was not specifically selected because of health concerns, and yet it includes women whose children had such extreme problems as cancer, cardiac ailments, HIV infection, seizure disorders, severe retardation, and mental illness — not to mention the health problems typically associated with poor urban children, such as asthma and lead poisoning.

---

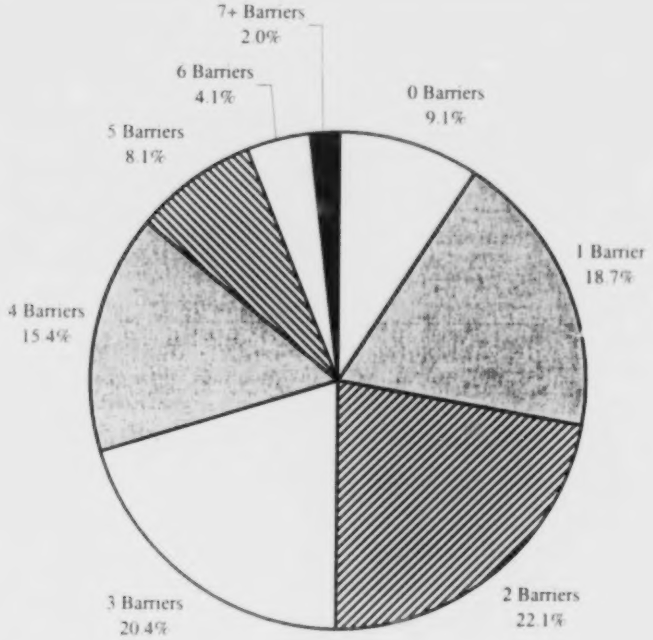
[4] The eight health problems in the health barrier scale include the following: being in poor physical health, as indicated by a low score on a health status scale; being at moderate or high risk of depression; having more than five doctor visits in the prior year; being morbidly obese; having been homeless or sheltered in the prior year; having used a hard drug (cocaine, heroin) in the prior month; having been physically abused in the prior year; and caring for a child with an illness or disability that constrained the mother's ability to work.

The Project on Devolution and Urban Change

Figure 1

Health and Nonhealth Barriers to Employment

Most women faced multiple health and nonhealth barriers to employment.



BEST COPY AVAILABLE

- **Women who were working — especially if they had left welfare — had better health and mental health outcomes than women who did not work, and they were less likely to have children with health problems.**

Table 3 summarizes key health outcomes for the four research groups. Across all outcomes considered in this table — and across many others discussed in the full report — women who had left welfare and were working had fewer health-related material hardships and were also healthier than women in the other three groups. Specifically, women in the work-only group were less likely than other women to be food insecure, to have housing problems, to have multiple material hardships, to be in fair or poor health, to have a work-limiting physical problem, to smoke, to be at risk of depression, to have been physically abused, and to have a child with an illness or health problem. Women in the two nonworking groups — whether they were still on welfare or had left — had similarly high rates of health problems. For example, about one out of three women in the two nonworking groups described themselves as being in fair or poor health. Women who combined work and welfare were in the middle of these two extremes with regard to virtually all indicators of health.

On the multiple health barrier index, women in the work-only group were least likely to have any of the eight health barriers — although, notably, 62.4 percent did have one or more (see Figure 2). Women who were working and still receiving welfare were somewhat better off than women in the two nonworking groups, but they nevertheless had more health problems than working welfare leavers. Women still on welfare and not working had the highest prevalence of multiple health problems.

It is important to note that the group differences in health outcomes do not merely reflect differences in the women's background characteristics. Health differences in the four work/welfare groups persisted even when such factors as age, education, number of children, citizenship status, and race/ethnicity were controlled.

- **The relationship between the women's employment status and their health most likely reflects the constraints that health problems pose for labor force participation.**

In a cross-sectional study with only one point of data collection, it is impossible to conclusively determine whether health problems affected women's employment, or vice versa. It seems plausible that employment itself could confer some health benefits on poor women — for example, by improving their financial situation and thus their access to material resources that can benefit health. However, there is substantial evidence in both the survey and the ethnographic data that the strong and consistent relationship between women's health and their employment status primarily reflects the effects of health problems on their decision or ability to work. For example, women in the two working groups were healthier than nonemployed women *even when total family income* and *health-related material hardships were statistically controlled* — which indicates that the women's financial resources do not account for the association between employment and health.

- **Among women still on welfare, the prevalence of health problems that could undermine employment consistently exceeded 20 percent.**

The prevalence of individual health problems among current welfare recipients was consistently in the 25 percent to 40 percent range. For example, 29 percent had a health condition

The Project on Devolution and Urban Change

Table 3

Selected Health Status Outcomes, by Mother's Work and Welfare Status[a]

Outcome (%)	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Food insecure[b]	48.8	***	41.8	49.5	52.5	55.4
Has 2 or more housing problems[c]	25.5	***	19.9	28.4	28.9	26.2
Has 3 or more material hardships[d]	28.1	***	19.3	26.4	35.6	30.6
Reports fair to poor health	25.5	***	17.2	20.0	32.1	35.0
Physical problem limits work or type of work	24.0	***	11.6	15.7	34.1	37.9
Currently smokes cigarettes	39.8	***	32.2	39.9	44.9	44.1
At moderate or high risk of depression[e]	27.2	***	19.9	23.6	32.7	34.8
Physically abused in past 12 months	8.8	**	6.6	7.6	10.4	11.1
Has an illness/disability that limits mother's work or school participation	19.8	***	13.0	18.6	25.0	23.1
Sample size	3,765		1,240	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[c] Respondents indicated whether they had any of the following housing problems: broken windows, leaky ceilings, roaches/vermin, and problems with wiring, plumbing, heating, and appliances.

[d] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has 2 or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

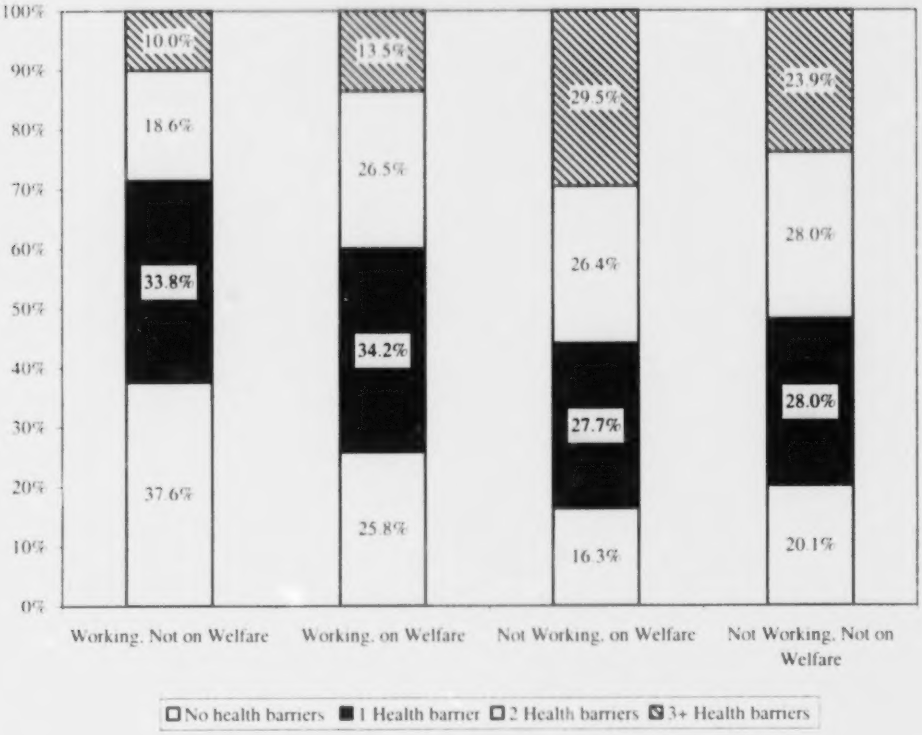
[e] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

The Project on Devolution and Urban Change

Figure 2

Health Barriers to Employment

Health barriers were most common among nonworking women.



BEST COPY AVAILABLE

that limited their ability to work, 30 percent were at high risk of depression, 41 percent had a health limitation that constrained moderate activities (for example, pushing a vacuum cleaner), and 23 percent had a child with a disability or illness that affected their employment. Since women having one such problem are not necessarily the same as those having another, the prevalence of *any* problem is substantially higher. Thus, on the multiple health barrier scale, nearly 80 percent of current recipients in the survey sample had at least one potential health barrier, and half had two or more. These rates are even higher among the welfare recipients who were not working, and so as the women who are able to work leave welfare, the percentage of the caseload with health problems will presumably increase.

- **The majority of women still on welfare said that they were subject to work or participation requirements. Only 14 percent said that they were exempt due to health reasons.**

About 40 percent of the women who were receiving welfare at the time of the 1998-1999 survey said that they were not required to engage in a work-related activity. The most commonly reported reason for an exemption was for a physical health problem of the woman herself (11.7 percent of recipients), and an additional 2.7 percent said that they were exempt because of the poor health of their child or some other family member. (The second most prevalent reason for an exemption was the age of the women's youngest child, reported by 7.7 percent of current recipients.) As a consequence, many women who reported health problems in the survey said that they were not exempt from participation. For example, nearly half (47.4 percent) of the women with three health barriers or more said that they were subject to the welfare agency's participation requirements.

- **Multiple health problems were related not only to employment and welfare *status* but also to the employment and welfare *experiences* of women.**

Among the women who were working, those with multiple health problems were less likely than those without such problems to be working full time, and they also worked in jobs with lower hourly wages. Moreover, even among those working full time, women with multiple health problems were less likely than other full-time workers to be working in jobs with fringe benefits, *including health insurance*. Health problems were also related to the timing of exits from welfare: Welfare leavers with health barriers were more likely than those without barriers to have left welfare recently (within the prior 12 months) and to say that they had been terminated by the welfare agency rather than that they had left of their own accord. Substantial percentages of women with multiple health problems who had left welfare had reapplied for welfare in the preceding year but had been denied. Among the women still on welfare, the greater the number of health barriers, the greater the likelihood that the woman had been sanctioned in the prior year.[5] Overall, nearly one-third of current recipients had been sanctioned; but women who reported being highly depressed, having been physically abused, or having a child with a serious health problem were significantly more likely to have been sanctioned than women without these problems. Among both welfare leavers and current recipients, women with health barriers were substantially less likely than other women to think that time-limited welfare is fair.

---

[5] A penalty involving loss of part or all of the cash assistance grant (and sometimes of other benefits as well) for a period of time because of noncompliance with welfare rules. A full-family sanction is a penalty for noncompliance with welfare requirements under which all members of a household receiving welfare have their cash grants (and sometimes other benefits) eliminated.

- **Health outcomes varied across the four sites, but not in a consistent fashion, and the same pattern of health-related differences among the four work/welfare groups was observed in all four sites.**

For most of the health outcomes included in the Urban Change study, there were significant site differences. However, the pattern of differences did not consistently point to one site's having better or worse health outcomes than others. For example, food insecurity was highest in Los Angeles; cigarette smoking was highest in Cleveland; and depression and physical abuse were highest in Philadelphia. Thus, despite significant site differences on individual health outcomes, women in the four sites did not differ on the multiple health barrier scale. Moreover, all four sites exhibited a comparable pattern in terms of work/welfare group differences. In every site, working women, especially those who had already exited welfare, had better health outcomes than nonworking women.

VI. Health Care Access and the Safety Net

Although health status was strongly linked to employment, health care access — and the use of other safety net programs — was associated with welfare receipt, which is consistent with the fact that welfare recipients are automatically eligible for Medicaid.

- **Women who had left welfare — whether they were working or not — were substantially less likely than women still on welfare to have health insurance.**

Women in the two groups of welfare leavers were more than *five times* as likely as the two groups of current welfare recipients to be uninsured in the month before the interview. As shown in Table 4, one-third of the women in the work-only group and about 45 percent of those in the no-work, no-welfare group did not have insurance in the month prior to the interview, compared with 6 percent among welfare recipients. Welfare leavers were also substantially more likely than current recipients to have had a spell without health insurance in the prior year. Figure 3 shows that substantial minorities (about one in four) of the women who had exited welfare had been *uninsured for the entire previous year*. Other family members, including children, were also affected by welfare exits. For example, as shown in Table 4, about 30 percent of the women who had left welfare had a child who was not insured in the prior month, compared with about 7 percent of the women still on welfare. Women who had left welfare were also substantially more likely to have had no insurance for the entire family in the prior month.

- **With respect to all other indicators of health care access, women who had left welfare had more problems than current recipients.**

Table 4 also shows that about twice as many welfare leavers as current recipients did not have a usual source of health care at the time of the interview. Moreover, welfare leavers were substantially more likely to say that someone in their family had needed medical or dental care in

The Project on Devolution and Urban Change

Table 4

Selected Outcomes Relating to Health Care Access and Food Stamp Benefits, by Mother's Work and Welfare Status[a]

Outcome (%)	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Uninsured, prior month	19.5	***	33.7	6.1	6.2	44.5
Ever uninsured, past 12 months	30.4	***	45.7	15.7	15.6	56.0
Everyone in family uninsured, prior month	11.2	***	20.9	1.8	2.6	26.5
Any uninsured child, prior month	16.5	***	27.8	6.8	6.7	34.5
Has no usual source of care	11.2	***	14.7	8.7	7.1	18.3
Anyone in family needed doctor but couldn't afford it	23.4	***	32.4	13.9	15.1	39.5
Anyone in family needed dentist but couldn't afford it	25.0	***	35.0	15.0	15.9	41.8
Did not receive food stamps, prior month	30.9	***	68.0	7.0	3.4	51.2
Food insecure with no food stamps, prior month[b]	13.0	***	26.0	3.4	1.8	27.5
Sample size	3,764		1,239	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

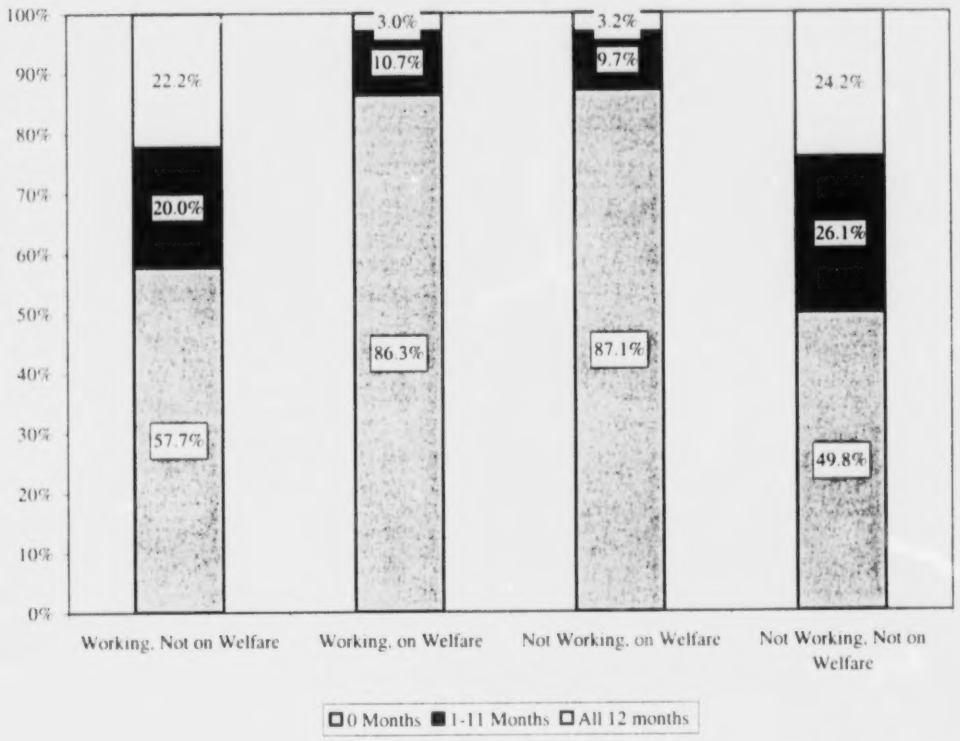
[b] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

The Project on Devolution and Urban Change

Figure 3

Health Insurance Coverage

Many welfare leavers had spells without health insurance.



BEST COPY AVAILABLE

the prior year but had been unable to obtain it because of financial constraints. Some 40 percent of those who had left welfare and were not working and 32 percent of those who were working reported an unmet need for medical care in their families, compared with about 15 percent of those still receiving welfare. Across all the indicators of access, then — whether pertaining to the women, their children, or other family members — current recipients fared better than former recipients, and they fared especially better than those who were not working.

- **The majority of women who had left welfare were not getting food stamps at the time of the interview.**

Among former welfare recipients, some 68 percent of those who worked and 51 percent of those who did not work no longer received food stamps. Yet, on the basis on their self-reported income, the majority of welfare leavers who were not receiving food stamps appeared to be eligible for this benefit (although information on the women's assets, which is also used in eligibility determination, was not available in the survey). As shown in Table 4, about one of every four former welfare recipients was food insecure but did not receive food stamps in the prior month. By contrast, only a handful of recipients had not gotten food stamps in the prior month and were food insecure.

- **There were significant site differences in safety net coverage.**

Miami was the only site where the majority of women (55 percent) in the survey sample had left welfare, in line with the fact that Florida had the sixth-highest rate of welfare caseload decline in the country for the 1996-1998 period. (By contrast, only 31 percent of the Los Angeles survey respondents had exited welfare.) Consistent with the fact that welfare exits were related to health care access problems, women in Miami had the highest rate of being uninsured in the prior month, of having a spell without insurance in the prior year, and of having an unmet need for medical or dental care in the prior year. For example, 30 percent of Miami respondents were uninsured in the month prior to the interview, compared with 13 percent of respondents from Philadelphia. However, it is important to note that all sites have taken steps since the 1998-1999 interviews to address problems with Medicaid coverage for welfare leavers. It should also be noted that, among the women who had left welfare, those in Miami were most likely to still be receiving food stamps (45.9 percent), while former recipients in Los Angeles (15.7 percent) were least likely to still be food stamp recipients.

VII. Health Patterns in the Four Work/Welfare Groups

The findings of the Urban Change health study indicate that the health situations of highly disadvantaged urban women cannot be adequately characterized by comparing welfare leavers with ongoing recipients or by comparing employed women with nonemployed women. *All four research groups had appreciably different health profiles* — profiles that were similar across the four Urban Change sites. The work/welfare groups are all of public policy interest because they pose distinct challenges — and also because the groups are undergoing changes in size and composition as a result of welfare reform. This section summarizes the characteristics and health circumstances of the women in the four work/welfare groups.

- **Compared with women in other groups, women who had left welfare and**

were working (the *work-only group*) were advantaged in terms of health status and most other indicators of emotional, financial, and social well-being — except for access to health care.

One-third of the women in the Urban Change sample were former recipients who were working. Most were high school graduates with one or two children (typically, school-aged). The majority worked full time (30 hours or more per week) in jobs that paid above the minimum wage and that offered at least one fringe benefit; about half had employer-provided health insurance for themselves. Women in this group typically had been working in their current jobs for more than one year, and three out of four had left welfare more than one year before the interview. Their total family income in the prior month (including food stamps, child support, and all family members' earnings but not including the Earned Income Tax Credit, housing subsidies, or the cash value of medical insurance) averaged just under $1,750, which would translate to about $21,000 annually.

For virtually every indicator in the survey, women who had left welfare for employment prior to reaching the time limits were the least disadvantaged group. They were better off financially and had fewer health-related material hardships than other women in the Urban Change sample: They were more likely to be food secure, had better-quality and safer housing, lived in less dangerous neighborhoods, and were less likely to have been homeless in the prior year. They were the healthiest group and were least likely to be at risk of depression or to report high levels of stress. They were also least likely to have been victims of domestic violence. Their children were healthier than children of other women, and their children also appeared to have other advantages, such as higher levels of contact with their fathers.

However, the work-only group was not fully protected by the safety net designed to safeguard the working poor. Nearly half these women had had a spell without health insurance in the prior year, and nearly a quarter had been uninsured the entire year. Even among those with stable, full-time employment (that is, working in the same job for at least one year), over one-third did not have health insurance as a fringe benefit. Some 40 percent of the women in the work-only group said that they or someone in their family had foregone medical or dental care in the prior year because they could not afford it. Fewer than one-third were receiving food stamps, despite the fact that more than half of those not receiving them appeared to be income-eligible.

Even though women in the work-only group were the healthiest and had the best material resources of any group, they were nevertheless mostly single mothers juggling jobs and parenting responsibilities while living in stressful and disadvantaged situations. Employed welfare leavers were more likely to be food insecure than those living below poverty nationally. And, *although healthier than women in the other groups, they were less healthy than same-aged women nationally*. Thus, it appears that many of those who had been able to leave welfare for employment still had health-related problems that might undermine permanent self-sufficiency, especially in light of health care access problems for themselves and their children.

- **Women in the *work-and-welfare group* were healthier and had more human capital resources than women in the two nonworking groups; additionally, by virtue of their Medicaid benefits, they had good access to health care.**

Women who combined work and welfare made up a relatively small proportion of the overall Urban Change survey sample (17 percent) but a noteworthy percentage of all current welfare recipients in the two welfare groups (30 percent). Until recently, relatively few recipients combined welfare and work; the growth of this group presumably reflects the more generous financial incentives that most states now offer recipients, allowing them to have more of their earnings disregarded for the purpose of computing welfare benefits.

Women in the work-and-welfare group, about half of whom had a high school diploma, were predominantly single mothers caring for two or more children, and most had a preschool-age child. The majority of women had held their current jobs for more than six months. Only about half had full-time jobs, and most had no fringe benefits. Fewer than one out of four had jobs with wages that would raise them above poverty if they worked full time. Their total family income in the month prior to the interview, including welfare and food stamp benefits but not the EITC, averaged about $1,400, which would translate to an annual income of under $17,000 per year.

Current recipients who worked had less favorable health outcomes than welfare leavers who worked, but they had consistently better outcomes than women in the two nonworking groups. For example, working welfare recipients were about half as likely as nonworking women to say that they had a physical problem or other health condition that limited the kind or amount of work they could do. In light of the fact that these women were already working, it seems likely that many of them will exit welfare before they reach the time limits. However, because of their more limited human capital resources than women in the work-only group, those in the work-and-welfare group appear even less likely to secure jobs with health benefits, even though their health problems suggest an even stronger need for health care access. These women may experience severe hardships in their transition off welfare without new policies that can guarantee them access to health care — and to food stamps, for which most will likely continue to be eligible.

- **Compared with women who worked, women in the *welfare-only group* had worse circumstances with regard to their material resources, their health status, and their children's health; but they had good health care access to address their health problems.**

Women who continued to receive cash welfare benefits and were not working composed 39 percent of the Urban Change sample — the largest of the four work/welfare groups. The majority of these women were not high school graduates, and about half had three or more children, at least one of whom was a preschooler. Typically, these women had not worked for pay at all in the prior year, and nearly one out of five had never worked for pay. This was the poorest of the four groups, with total family income from all sources in the prior month averaging $935, which would be an average annual income of about $11,000.

Women in the welfare-only group were living in the least healthful circumstances by virtue of having multiple, and severe, material hardships. The majority were food insecure, and yet they spent, on average, over one-third of their total family income (including food stamps) on food. These women tended to live in poorer-quality housing and resided in more violent, more dangerous neighborhoods than women in the other groups. Many women in the ethnographic sample — the vast majority of whom were nonworking welfare recipients — described extensive crime, drug use, and gang activities in their neighborhoods, and they discussed how fears about personal safety for themselves and their children kept them hostages in their own homes.

Women in the welfare-only group were also the least healthy of women in the Urban Change sample, with about one out of three reporting a health condition that limited the amount or type of work they could perform. The majority were at risk of depression and reported high levels of stress. One out of four had a child with a physical problem that constrained employment options. Welfare recipients in the ethnographic sample provided powerful stories about how their children's health problems — often quite serious ones — hampered their ability to work and to comply with the welfare agency's participation requirements. Overall, three times as many of these women had multiple health barriers as had none (56 percent versus 16 percent). However, these women had good access to health care to address their various health problems through Medicaid. As has been found in other studies, they worried substantially more about losing medical benefits than about losing cash assistance — and they had tremendous anxiety about how they would care for their sick children when they were working.

Many women in the welfare-only group could be characterized as "hard to employ" and may well not be able to secure paid employment before they reach their time limit. The majority not only had multiple health barriers but also were handicapped by poor education credentials and limited work experience. Health problems may have also interfered with their ability to comply with the welfare agency's participation requirements. Most of these women will likely have difficulty making a transition off welfare.

- **Women in the *no-work, no-welfare group* had the most compromised health situations, including the most unfavorable health profiles and the most severe health care access problems of any group.**

Women who had left welfare and were not working composed 11 percent of the survey sample. These women were more likely to be married than those in other groups. Additionally, their children (and they themselves) tended to be older. About half did not have a high school diploma, and one out of ten said that they could not converse in English. The majority had not worked for pay at all in the prior year, and most had not collected any welfare benefits in that period — although only a small minority reported no source of income in the prior month. The most important income source was from the paid employment of another household member. This group was nearly as disadvantaged financially as the welfare-only group, with an average total family income from all sources of just over $1,000 in the prior month, or roughly $12,000 annually.

For many health outcomes, this group had the highest prevalence of problems. For example, women who neither worked nor received welfare were most likely to be food insecure, to say that they were in fair or poor health, to have unfavorable scores on a standardized measure of physical health status, to be at high risk of depression, and to have been physically abused in the prior year. Overall, their health situations looked similar to those of women in the welfare-only group, with one critical exception: Nearly half were uninsured, and over one-third had a child who lacked health insurance. Two out of five of these women had unmet medical and dental needs in their families. Fewer than half of the women in this group lived in households that received food stamps, and yet over 80 percent of the nonrecipients appeared eligible on the basis of their income.

Some of the women in this group appeared to be no longer eligible for TANF assistance, because they no longer had an age-eligible child, or because of their marital status, or because they had already moved into a disability assistance program. Others, however, seemed at high risk of returning to welfare in light of health-related and other constraints to employment and given their need for health insurance.

VIII. Implications of the Findings

Welfare reform is being widely hailed as a success because of declining welfare caseloads. In fact, the Urban Change survey data indicate that *substantial numbers of welfare recipients from even the most disadvantaged urban neighborhoods have been able to secure fairly stable employment* — notwithstanding the fact that most of them have at least one health-related or human capital barrier to employment. However, both the women who have left welfare and those who remain on the rolls face issues that merit the scrutiny of policymakers, welfare staff, and service providers.

- **The women who have remained on welfare despite encouragement to find a job, impending time limits, and the strong economy have multiple health and other impediments that pose powerful challenges to welfare agencies.**

Although most women who had left welfare and were working had potential barriers to employment, these women nevertheless had better education credentials, more prior work experience, fewer children, and far fewer health problems than women who continued to receive cash assistance. In particular, current recipients who were not combining work and welfare despite current financial incentives to do so appear to include women who may not be immediately employable. With the time limits approaching for many of them, welfare agencies face unprecedented pressures to prevent current recipients from losing their benefits without having a job — as well as pressures resulting from the fact that caseloads increasingly comprise women with complex health-related problems.

- **Effective strategies to address the needs of the hard-to-employ need to be identified and replicated.**

Some of the barriers of welfare recipients — such as having chronic health problems or several children with illnesses — may be too intractable to remedy to the point where the women could become totally self-sufficient. Other health barriers identified in this study, however, could be diagnosed and possibly improved through interventions. In particular, substance abuse and mental health services may prove to be critical to certain segments of the welfare caseload — as well as to women who leave welfare for work and find it difficult to sustain employment. Substantial percentages of women in all four work/welfare groups were at high risk of depression, and major depression is the leading cause of disability in the United States. It seems possible that aggressive mental health and related services could have favorable effects on the ability of these women to enter — and remain in — the labor force. It is also possible that a combination of services and temporary extensions of the time limit will be required to address some of the complex psychosocial issues confronting many welfare recipients remaining on the caseloads. Many welfare agencies are taking advantage of the exceptional opportunities they have now to experiment with alternative service packages and intervention strategies as a result of the programmatic (and fiscal) flexibility they now enjoy under PRWORA. In many cases, strategies to work with the hard-to-employ involve collaborations with other service providers, which seems essential, given the complexity of these women's problems. With the federal time limits looming large, reliable information on the effectiveness of these strategies is becoming crucial.

- **As more and more women reach the time limits, it may prove necessary to reassess the policy of restricting exemptions from the five-year limit to 20 percent of the caseload — or the policy of having a two-tiered system of exempt and nonexempt recipients.**

PRWORA's 20 percent exemption policy was based on a preliminary estimate of the proportion of recipients who would face insurmountable barriers to employment and thus would require ongoing cash assistance. Based on the data from the Urban Change survey, it seems possible that more than 20 percent of these women may need an exemption from — or an extension of — the time limit. It is, of course, important to remember that the sample is not representative of all welfare recipients and that the Urban Change data are nonclinical and therefore have limitations as formal measures of health status. Nevertheless, among the women most at risk of reaching their time limit without a job — that is, among women in the welfare-only group — the great majority appear to have serious and multiple impediments to employment. And as the number of recipients continues to decline by virtue of exits due to employment, recipients with multiple barriers will dominate the remaining caseload, and there will be fewer and fewer women in the "base" for calculating the exemption rate.

A related issue is that current policy establishes a two-tiered system (a three-tiered system, if SSI is included) to characterize the employability of welfare recipients: In the first tier, a minimum of 80 percent are presumed employable and capable of becoming self-sufficient; and, in the second tier, up to 20 percent are presumed to have a more permanent need for cash assistance without being required to work. In fact, as this report describes, there are varying degrees of employability that are tied to recipients' human capital resources, their life experiences and circumstances, their health and mental health conditions, and their children's health. The degree to which a person is healthy enough to work is more on a continuum than a yes-or-no issue; more dynamic than static; and also depends on what supports (for example, health insurance) are available. Thus, there could be inherent problems in having such sharp cutoff points that, on the one hand, *require* 80 percent to leave welfare within five years without further cash assistance and, on the other hand, do *not* require the remaining 20 percent to participate in services that could benefit them and their families. It may be appropriate to consider alternative policies that give states greater flexibility (or financial incentives) to develop the most suitable plan for recipients at all points along the employability continuum. And states might wish to explore alternative kinds of work activities for some cases — such as supported work, which entails closely supervised job training for small groups of people facing similar barriers to employment.

- **In a time-limited welfare environment, appropriate screening procedures appear essential for policy planning purposes and for a fair and effective programmatic response to women with health-related barriers.**

Without time limits, states might be justified in simply identifying hard-to-employ cases by seeing who on the caseload cannot find a job. However, intervention strategies for recipients with a severe health-related problem or multiple barriers to employment will likely take time to succeed, suggesting the need for early identification — not when recipients are within months of hitting the time limit. Although welfare agencies may be reluctant to slow down the process of moving recipients into jobs quickly by instituting universal, in-depth assessments, there may be a benefit in instituting simple, low-cost screening procedures, either at intake or after a brief job search period. For example, Los Angeles County's welfare-to-work program has begun using a short, self-administered questionnaire during the intake process that asks about substance abuse, mental health problems, and domestic violence. Clients who indicate that they may have a problem are referred immediately to a social worker for a clinical assessment. Although such screening will not identify all women with problems, it will likely provide data for improving large-scale planning (about sanctioning policies, for example, or resource allocation) and for developing a course of action for many women who require substantial assistance in leaving the welfare rolls.

- **Health problems not only constrain employment but also appear to constrain recipients' ability to comply with participation requirements, raising questions about current sanctioning policies.**

Sanctioning is increasingly viewed as an important tool for encouraging compliance with mandated welfare-to-work activities and work requirements. A number of states — including three of the four involved in this study — have instituted full-family sanctions (that is, a total cutoff of all TANF benefits) as a penalty for noncompliance, and sizable percentages of recipients in the survey sample (nearly one-third) reported having been sanctioned in the prior year. The findings from both the ethnographic study and the survey suggest, however, that noncompliance may in some cases reflect genuine health-related obstacles that recipients face. A particular concern is that more than 40 percent of the women who had been physically abused in the prior year, compared with 29 percent of nonabused women, reported having been sanctioned. These findings suggest that states should reevaluate their sanctioning policies and explore and evaluate mechanisms for special outreach (such as home visits and in-depth assessments) to families in sanction status. For example, in Cleveland the welfare agency has contracted with nonprofit social service agencies to make home visits to every family who is sanctioned for noncompliance with welfare-to-work requirements. The home visitors are trained to identify barriers and to arrange for services that could help the family regain compliance.

- **Given the health care needs identified in this study, an especially critical policy challenge is the development of mechanisms to ensure that women who leave welfare maintain their health insurance coverage.**

It is laudable that recent initiatives have made an increasingly large number of low-income children eligible for health insurance through Medicaid expansions and the Children's Health Insurance Program (CHIP). However, the disparity in policies for low-income women and low-income children merits scrutiny. The women in the Urban Change population were less healthy than their children, yet they were less likely to have insurance and less likely to have access to health care — even though *they* were the ones who shouldered the responsibility for raising and financially supporting their children. Maintaining health insurance coverage among those who leave welfare is a two-pronged issue. First, it is important to put into place strategies to ensure that eligible women receive the health insurance benefits to which they are entitled when their TANF benefits are terminated. All four Urban Change sites have taken steps since the survey data were collected to improve the delivery of transitional Medicaid benefits. Second, consideration needs to be given to mechanisms for making health insurance available to women who are not currently eligible. Some employed welfare leavers would not qualify for Medicaid on the basis of their earnings, yet they are clearly in need of insurance. There are several ways by which better access to insurance could be achieved, including incentives to employers, further expansions of Medicaid eligibility, Medicaid buy-in plans, and state-funded insurance programs.

- **Closely behind the need for improved policies and procedures relating to Medicaid is the need for closer examination of food stamp benefits for transitioning welfare recipients.**

Adequate nutrition is a prerequisite for health and well-being, and food stamps are the central policy tool for providing nutritional assistance to low-income families. Most welfare recipients who leave welfare continue to be income-eligible for food stamps, but there is increasing evidence — including findings in the current study — that many eligible families do not receive food stamp benefits. In the work-only group, only about one-third of the women were food stamp recipients, despite the apparent eligibility of most nonrecipients. And in the no-work, no-welfare group, over 80 percent of those not receiving food stamps appeared eligible. Data from this study as well as other studies of welfare leavers suggest that steps need to be taken to ensure that women who leave welfare for work obtain food benefits for which they are eligible. The steps could include (1) better training of caseworkers so that they fully understand new eligibility rules and are aware of the importance of consistently and regularly communicating this information to clients; (2) better use of technology to identify qualified welfare leavers who are eligible for food stamps; (3) outreach to welfare leavers to notify them of eligibility; (4) more convenient office hours and mechanisms for employed people to apply for benefits or get recertified (such as mail-in recertification and "one-stop" locations for various services and benefits); and (5) outreach at food pantries or other community locations that serve the needs of the poor.

- **In all policies arenas relating to public assistance, it is critical to anticipate the inevitability of an economic downturn and to take employment barriers into account in planning for such a downturn.**

In a strong economy such as the current one, a single barrier might have minimal effects on women's employment. As the impediments mount up, the obstacles presumably become increasingly difficult to overcome — both because the women themselves have to cope with the barriers and also because they become less attractive to prospective employers. In a less favorable economy, however, employers can be more selective in hiring — and less cautious about firing. Women with even one health-related or other employment barrier may find it substantially more difficult to transition from welfare to work, and to sustain jobs, in a different economic climate. Anticipating such change could lead, for example, to the development of formulas tying the unemployment rate to exemption criteria, rates of exemptions, and extensions of the time limits.

In conclusion, it is clear that, as public policymakers head toward decisions about the reauthorization of PRWORA (scheduled to occur by 2002) and about features that can improve the success of this legislation, the health and health care needs of welfare recipients in urban areas warrant special consideration.

Chapter 1

Introduction

The link between health and poverty is firmly established: There are few indicators of morbidity and mortality that have *not* been found to be more prevalent among the economically disadvantaged than among those with higher incomes. This link, which has long been recognized, makes poverty a major public health concern.

Despite the growth of the U.S. economy in the past five years, millions of American families continue to be poor. In 1999, 9.3 percent of all families (6.7 million families) were below the official federal poverty level. And, while the family poverty rate declined from 11.6 percent in 1994, the poverty rate for children living in female-headed households was fairly stable during that same period (57.7 percent in 1994 and 57.4 percent in 1999) (U.S. Bureau of the Census, 2000a).

Poor single women with children rely on a variety of public assistance programs to house, feed, clothe, and care for the health needs of their families. However, the policy landscape affecting these families has changed dramatically in recent years. In particular, welfare policy was revolutionized with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), enacted in August 1996. One of the key features of this act is that it places a five-year lifetime limit on federally funded cash benefits for most recipient families. As increasing numbers of poor families move toward the termination of cash benefits, there is considerable interest in understanding the implications of changes in welfare policies and programs on the health and well-being of children and their parents. On the one hand, supporters of welfare reform expect that time limits in conjunction with enhanced but temporary assistance will promote self-sufficiency and improve the financial situation of poor families in the long run. On the other hand, critics predict devastating effects on families — increased poverty, more homelessness and housing problems, greater food insecurity and hunger, and loss of health insurance and health care access.

There is also interest in understanding how health and other factors constrain recipients' ability to comply with welfare participation requirements and to secure stable jobs. Accurate descriptions of the magnitude and nature of health problems that recipient (and former recipient) families face are needed to inform the development or refinement of policies affecting those families — including both social welfare and health policies. There is little systematic, detailed information about the health of the current welfare population or about characteristics associated with better health outcomes among recipients. Using unusually rich data from multiple sources, this report describes the health and well-being of women who either had been welfare recipients or were still recipients and who, therefore, were at especially high risk of being affected by welfare reform policies. As a cautionary note, it is important to recognize that the data for this report were collected in 1998-1999, before time limits had been imposed; thus, the findings do not offer evidence on how welfare reform will ultimately affect health outcomes or on how health factors will affect the success of welfare reform. Rather, they provide an early snapshot of a vulnerable group potentially facing time-limit pressures and loss of benefits that can affect their health and well-being.

I. The Urban Change Study

This report is based on data from the Project on Devolution and Urban Change (Urban Change, for short), which is being undertaken by the Manpower Demonstration Research Corporation (MDRC) in collaboration with colleagues at a number of academic institutions and with the cooperation of public agencies in the four states where the study is being conducted. MDRC is a nonprofit, nonpartisan organization that develops and evaluates interventions designed to improve the well-being and self-sufficiency of economically disadvantaged populations. The Urban Change project is supported by a consortium of foundations and government agencies, which are listed at the front of this report.

The Urban Change project is a five-year multicomponent study of the implementation and effects of PRWORA on poor families with children and the neighborhoods in which they live. The study is being conducted in four large urban counties: Cuyahoga, Ohio (Cleveland); Los Angeles, California; Miami-Dade, Florida; and Philadelphia, Pennsylvania.[1] The Urban Change project is one of a number of studies currently under way that are examining the implementation and effects of PRWORA. The Urban Change project is distinctive in a number of respects and is expected to yield data of unparalleled breadth and depth that can be used to address many questions of relevance to policymakers and practitioners.

One distinctive aspect of the Urban Change project is its urban focus, which was based on the assumption that the effects of welfare reform — favorable or unfavorable — will be most evident in urban areas, where poverty and welfare receipt (and public health problems) are concentrated. Indeed, the great majority of welfare recipients in the United States live in urban areas. Nearly one-third (32.7 percent) of all welfare recipients in 1999 lived in 10 of the largest urban counties (three of which are Urban Change sites — Cuyahoga, Los Angeles, and Philadelphia), and that percentage has been growing. In fact, in 1999, some 14 percent of all welfare recipients in the United States lived in the four Urban Change counties (Allen and Kirby, 2000). Thus, the greatest challenges of welfare reform increasingly are unfolding in the nation's large urban areas.

A second noteworthy aspect of the Urban Change project is its multidisciplinary nature. The study involves five distinctive components that are designed to complement each other and that will be carefully integrated to provide a rich, comprehensive description of the welfare reform stories that are unfolding in the four Urban Change sites. Table 1.1 summarizes the major features of the five study components. A third unique characteristic of Urban Change can be seen in this table: The study has the potential to answer questions about welfare reform at different levels of aggregation and from different perspectives. The project will analyze and integrate multicomponent data to answer questions about PRWORA in relation to individual recipients, their children, the neighborhoods in which they live, and the welfare agencies and other providers that serve them.

Information about the early experiences of implementing PRWORA in the four Urban Change sites, using data from both the ethnography and the implementation components, has been published in a report by Quint et al. (1999). The current report uses first-round data from

---

[1] For brevity's sake, the sites (that is, the counties) are often referred to in this report by the names of their principal cities: Cleveland, Los Angeles, Miami, and Philadelphia. Only in the case of Philadelphia, however, are the city and county identical in their boundaries.

The Project on Devolution and Urban Change

Table 1.1

Key Features of the Urban Change Project

Goal
To understand how state and local welfare agencies, poor neighborhoods, and low-income families are affected by the changes to the income support system in response to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

Locations (sites)
Four large urban counties: Cuyahoga (Cleveland, Ohio), Los Angeles, Miami-Dade, and Philadelphia

Time frame
1997–2002

Project components
The *Ethnographic Study* illuminates the effects of the changes by chronicling, in depth and over time, how approximately 40 welfare-reliant families in each site cope with the new rules and policies.

The *Implementation Study* describes both the new welfare initiatives — rules, messages, benefits, and services — that are developed at the state and local levels and the experiences of the local welfare agencies in putting these new initiatives into practice.

The *Individual-Level Impact Study* measures the impact of the new policies on welfare, employment, earnings, and other indicators of individual and family well-being, via two components:

1. an *administrative records component*, for countywide samples of welfare recipients and other poor people
2. a *survey component* involving two waves of in-person interviews with a sample of residents of high-poverty neighborhoods

The *Institutional Study* examines how the new policies and funding mechanisms affect nonprofit institutions and neighborhood businesses.

The *Neighborhood Indicators Study* assesses changes in statistical indicators that reflect the social and economic vitality of urban counties and of neighborhoods within them where poverty and welfare receipt are concentrated.

Distinctive features
Its urban focus. The project examines the impacts of welfare reform in America's big cities.

Its neighborhood focus. All five components of the project will focus especially on residents of high-poverty neighborhoods, the public and nonprofit agencies that assist them, and the effects of welfare reform on the stability and vitality of their communities. Findings will also be reported at the county level.

Its effort to integrate findings across the components. The goal of the project is to bring multiple data sources and methodologies to bear in answering the questions of interest. The results of the separate studies are intended to illuminate, clarify, reinforce, and otherwise complement each other, as exemplified in this report.

the survey and ethnographic components of the study, collected shortly after PRWORA was implemented, to provide a descriptive baseline against which changes in the population and possible effects of welfare reform can be assessed.

The first wave of the Urban Change survey involved in-person interviews in 1998-1999 with women who were public assistance recipients prior to welfare reform.[2] Specifically, the survey sample comprises women who, in May 1995, were single mothers receiving welfare and/or food stamp benefits and who were living in neighborhoods (census tracts) characterized by high rates of poverty (30 percent or more of households) or welfare receipt (20 percent or more of households). Using data from administrative records, the survey sample was randomly selected from recipients who met the eligibility criteria, which are summarized in Table 1.2. The sample consists of approximately 1,000 women per site, for a total of 3,960 respondents (78.6 percent of those who were randomly sampled).[3] The survey interviews covered a wide range of topics, including the mothers' employment and income, household structure and living conditions, health and health care coverage for themselves and their children, and their families' material hardships.

The ethnographic study involves semi-structured, in-person interviews over a three-year period, with ongoing interim contact, with a sample of approximately 40 welfare families in each Urban Change city (none of the women in the ethnographic sample was also in the survey sample). As shown in Table 1.3, the sample was drawn from three low-income neighborhoods per site that varied in terms of the neighborhood's ethnic composition and poverty level. The ethnographic interviews cover many of the same issues as the survey,[4] but they yield richer, narrative data about how the families are coping with the new welfare rules and policies. Ethnographic data from the first round of interviews, completed in 1998, were available for analysis for this report.

II. The Welfare Policy Context

In the long-standing welfare policy debate about who is or is not deserving of public support, health status has always been one consideration. Reflecting this, the Social Security Act of 1935 provided federal funds for state welfare programs covering two groups of people who were not expected to work: first, the aged, blind, and disabled (who received Supplemental Security Income, or SSI, benefits); and second, single mothers, who became eligible for public welfare assistance because society saw an explicit value in providing for the care of needy children in their own homes, by their mothers. In the subsequent 65 years, however, the growth of the welfare rolls, changes in the demography of the welfare population, and the increasing movement of women (including mothers with very young children) into the labor force have eroded the legitimacy of defining welfare as an alternative to work. Accordingly, starting with the Work Incentive

---

[2] The second wave of the survey with this same sample has already been fielded.

[3] Appendix A provides detailed information about the survey response rate and a preliminary analysis of response biases.

[4] In the first round of ethnographic interviews, health-related topics were not covered in great depth in the topic guide. However, health issues and concerns emerged spontaneously in the course of the interviews, providing rich — albeit not systematic — data for many topics. Because health was such a salient issue, specific health questions were added to the topic guides for subsequent rounds of ethnographic interviews.

The Project on Devolution and Urban Change

Table 1.2

Key Features of the Urban Change Respondent Survey

Sample selection criteria	Receiving cash welfare and/or food stamp benefits May, 1995 Single mothers age 18-45 in May 1995 One or more child on assistance case in May 1995 Living in census tracts where either poverty rate exceeded 30% or welfare rate exceeded 20% of households in May, 1995 Able to conduct interview in either English or Spanish at the time of the interview
Sampling method	Simple random sampling
Source of sample information	Administrative records from the welfare/food stamp agencies in the four sites
Survey design	Cross-sectional interviews (interviews with sample members at one point in time) with two separate cohorts of eligible women
Survey fielding dates	March 1998 to March 1999
Survey mode	Computer-Assisted Personal Interview (CAPI) or Computer-Assisted Telephone Interview (CATI; if sample member lived more than 50 miles from any of the four sites).
Average interview length	80.3 minutes
Languages	English and Spanish
Response rate	78.6%[a]
Final sample size	3,960
Survey contractor	Institute for Survey Research, Temple University

NOTE: [a] See Appendix A for information about survey response rates and response biases.

The Project on Devolution and Urban Change

Table 1.3

Key Features of the Urban Change Ethnographic Design

Sample selection criteria	Receiving cash welfare and/or food stamp benefits at time of recruitment Mothers with 1 child or more living in household Living in selected neighborhoods (3 per site)[a] Able to conduct interview in an appropriate language (see below)
Sampling method	Convenience (recruitment through community agencies/fliers)
Design	Longitudinal annual in-depth interviews for 3-5 years, with regular (at least quarterly) interim updates on status
Initial interview dates	July 1997-April 1998
Interview mode	Personal interviews for all annual interviews and for most interim contacts (telephone interviews for some interim contacts)
Interview length	2-6 hours for in-depth interviews
Languages	English in Cuyahoga and Philadelphia Counties; English, Spanish, and Cambodian in Los Angeles County; English, Spanish, and Creole in Miami-Dade County)
Initial sample sizes	Cuyahoga County 47 Los Angeles County 46 Miami-Dade County 39 Philadelphia County 39 Total 171

NOTE: [a]Neighborhoods were selected to vary by ethnic composition and poverty level. The neighborhoods are

Cuyahoga County:	Detroit Shoreway (white); East Cleveland (African-American); Glenville (African-American)
Los Angeles County:	Boyle Heights (Mexican-American); Long Beach (Mexican immigrant); Long Beach (Cambodian immigrant); Westmont-West Athens (African-American)
Miami-Dade County:	Liberty City (African-American); Little Haiti (Haitian immigrant); Hialeah (Hispanic)
Philadelphia County:	Kensington (white); Germantown (African-American); North Central (African-American)

43

Program (WIN) in 1971, Congress has defined an ever-expanding group of single mothers on welfare as employable and subject to participation and work requirements, with the key exceptions being tied, until recently, to the age of the youngest child and the health of the mother or her children. For example, prior to the passage of PRWORA in 1996, women with children under age 3 (or under age 1, at the option of the state), or who were *ill or incapacitated or taking care of a household member who was ill or incapacitated,* could not be required to participate in welfare-to-work programs.

The 1996 PRWORA legislation took one further step in this evolution by dropping the language that excuses people from mandatory participation for health reasons. Participation requirements and time limits now extend to the full welfare caseload. Excluding those who meet the stringent SSI disability definition, the new policy defines all welfare recipients as employable, with the exception of an undefined 20 percent who may be excused from the federal time limits for "good cause."

PRWORA introduced a number of other changes as well. It replaced the previous cash welfare program (Aid to Families with Dependent Children, or AFDC) with a new form of aid called Temporary Assistance for Needy Families (TANF), whose name expresses the intent that welfare be a temporary source of financial support to those in need. PRWORA, which ended the entitlement to cash assistance, provides lump-sum block grants to states and gives them unprecedented discretion and responsibility — and funding levels — for developing their welfare programs. However, the legislation involves certain federal mandates, notably, a five-year lifetime limit on federally assisted cash benefits for most families (including adults and their dependent children). States are authorized to impose shorter time limits if they choose to do so, but states can also use their own funds to support families after the five-year limit through extensions of the time limit. Under PRWORA, states may also grant exemptions from the federal time limit, but the number of exempted families may not exceed 20 percent of the average monthly caseload in the state. PRWORA also places more stringent work and participation requirements on welfare recipients than had previously existed, requiring most of them to go to work no later than two years after becoming eligible for TANF benefits.[5] To meet the new work and participation requirements, states must now engage most of their caseloads in welfare-to-work programs. Thus, *an implicit assumption of PRWORA is that the great majority of recipients are sufficiently healthy and employment-ready to participate in mandated work-related activities* and, eventually, to become self-sufficient through employment.

Under PRWORA, states have great latitude in designing their own welfare policies and programs, as well as certain policies relating to food stamps and medical assistance — benefits that have clear health implications. For example, states make decisions regarding clients' work and participation requirements; criteria for exemptions from or extensions of the time limits; receipt of transitional services such as child care and medical assistance after welfare exit; sanctioning policies; eligibility criteria for Medicaid; and benefits for immigrants. In addition, states can place even more stringent time limits on clients' receipt of cash aid than the five-year limit mandated by the federal legislation. As a consequence, each state now runs its own individualized welfare program.

---

[5] However, most states now offer more generous financial incentives — that is, income disregards for calculating cash welfare benefits — than were previously available.

Recipients in the four sites selected for the Urban Change project are subject to substantially different rules, procedures, and programs. All the states, however, face one new challenge in common: They are being forced under the PRWORA provisions to work with many recipients who would have been granted exemptions under the previous welfare-to-work program — including those with health, mental health, domestic violence, and substance abuse problems.

Thus far, there have been some encouraging early signs about certain aspects of welfare reform. In particular, despite the fact that the five-year federal time limit has not yet been reached by those who were receiving benefits when the legislation was enacted in 1996, the welfare rolls have dropped sharply, both nationally and in all 50 states.[6] Nationally, between August 1996 and December 1999, welfare caseloads declined by 49 percent (from 12,242,000 recipients to 6,275,000 recipients) (U.S. Department of Health and Human Services, 2000c). In the four states involved in the Urban Change study, caseload declines over the same period range from 48 percent in California to a high of 68 percent in Florida.[7]

Many factors undoubtedly have contributed to these caseload declines, including the strong economy and greater availability of jobs, the raise in the minimum wage, new child care subsidies, and the expansion of the Earned Income Tax Credit (EITC), which is a special tax credit primarily benefiting low-income working parents.[8] But welfare reform has also played a critical role. While time-limit terminations have not yet directly reduced the caseloads in most states, welfare reform's emphasis on work has undoubtedly led many to have earnings sufficiently large to make them ineligible for cash assistance. Additionally, part of the decline likely reflects a "signaling effect" whereby some women leave the welfare rolls before they are actually required to do so, because of their awareness of the time limits and new work and participation requirements or because they want to "bank" their remaining months of welfare eligibility for later use. Declining caseloads may also reflect some deterrent effects; that is, messages about work requirements and time limits may deter some people from applying for welfare.

However, the rapidly declining welfare caseloads have given rise to concerns about recipients who have remained on the rolls during this era of economic prosperity — in particular, about the barriers they face to employment and about possible strategies for moving them into the labor force. At the same time, there is interest in the fate of recipients who have left welfare — how well they are managing, how stable their employment situations are, and how successful they have been in accessing services that support their transition to employment. Of particular interest is access to two key safety net programs that are relevant to the health of poor families: food stamps and medical assistance.

---

[6] In several states, however, there are interim-termination time limits that *have* already gone into effect. For example, in Florida, recipients who are not long-term recipients are allowed to receive cash benefits for only 24 months in any 60-month period; the first group hit the time limit in October 1998, although virtually everyone at that time was given an extension. Long-term recipients and custodial parents under age 24 who have no work experience and/or no high school diploma can receive welfare for 36 months in a 72-month period in Florida (Quint et al., 1999).

[7] While caseloads are also declining in urban areas, caseloads are shrinking at a slower pace in cities than elsewhere. For example, between 1994 and 1998, caseloads declined by 45 percent in Ohio, but they declined by only 31 percent in Cuyahoga County (Cleveland). Thus, welfare caseloads are increasingly concentrated in urban areas (Center on Urban and Metropolitan Policy, 1999).

[8] Meyer and Rosenbaum (1999, 2000) found that a large share of the increase in employment among single mothers since the mid-1980s can be attributed to the EITC rather than to changes in welfare policies or child care expansions.

The Food Stamp Program was scaled back through several PRWORA provisions, including overall reductions in the calculation of benefits. Also, states can now put certain food stamp rules (for example, rules about sanctions) in conformance with rules in their cash assistance programs. Nevertheless, food stamp benefits have continued as one of the few federal entitlement programs and are considered a cornerstone of aid to the working poor. During the 1994-1999 period, however, participation in the Food Stamp Program declined by 33 percent, with most of the decline occurring between September 1996 and September 1997 (U.S. Department of Agriculture, 1999). This reduction in the use of food stamps has been found to be larger than can be accounted for by the improved economy or welfare reform (Figlio, Gunderson, and Ziliak, 2000). Despite the fact that most former welfare recipients remain eligible for food stamps even if they work, it appears that some families leave the Food Stamp Program when they exit welfare. For example, Zedlewski and Brauner (1999) found that about two-thirds of former welfare recipients who also left the Food Stamp Program had incomes within the food stamp eligibility range.[9] These and other similar findings have led to concern and deliberation about the nutritional status of poor families leaving welfare.

Similar concerns exist in regard to health insurance. Until the passage of PRWORA, cash assistance and Medicaid (the federal program providing health insurance to the poor) were linked, and AFDC families were automatically eligible for Medicaid. However, in recognition of the fact that most women who leave welfare for low-wage jobs do not get employer-provided health insurance, Congress tried to minimize adverse effects of welfare reform on health care coverage by severing the ties between Medicaid eligibility and eligibility for cash aid under TANF. States are now required to provide Medicaid coverage to families who meet income and family structure guidelines that applied to the AFDC program on July 16, 1996, even if those families do not meet their state's new cash assistance criteria.[10] Thus, there is no time limit for Medicaid benefits — although wage-earners qualify only if their incomes are very low.[11] Additionally, in 1997 Congress passed a major health care expansion, the Children's Health Insurance Program (CHIP), a voluntary matching program that allows states to expand health insurance for uninsured children in low-income families.

As is the case with food stamps, many children and their parents who are eligible for Medicaid and CHIP coverage appear not to have enrolled. In 1996, for the first time in about a decade, the number of people insured by Medicaid declined and has continued to decline, while the uninsurance rate has increased (Ku and Bruen, 1999), leading to speculation that an unintended consequence of welfare reform is the loss of health care insurance for many low-income families. One measure of success in retaining Medicaid coverage for those leaving welfare is the overall change in caseload, combining Medicaid cases linked to cash benefits and those not so linked. Nationally, the caseload for nondisabled adult and child Medicaid cases fell by 5.3 percent from 1995 to 1997, indicating that the increase in enrollment for noncash cases did not fully offset the loss of enrollees on AFDC/TANF. However, states varied considerably with regard to this indicator; some states experienced an *increase* in total Medicaid enrollment despite TANF reductions (for example, Oregon had an increase of 29.5 percent), while other states had a very sharp decrease. Ohio, one of the four states in the Urban Change study, experienced one of the largest decreases (-18.4 percent), while in California the reduction was modest (-2.1 percent) (Ku and Bruen, 1999).

---

[9] For a discussion of welfare agency practices relating to Medicaid and food stamp benefits for those leaving welfare, see Quint and Widom, 2000.

[10] States have the option of lowering income limits on eligibility to the levels that applied on May 1, 1988.

[11] In about half the states, parents are ineligible for Medicaid if they earn more than 60 percent of the federal poverty level. Children, however, are eligible for Medicaid at higher income levels, and children's eligibility for the Children's Health Insurance Program (CHIP) is even less restrictive.

Caseload declines are partly attributable to the fact that some welfare leavers have earnings that make them ineligible for Medicaid once their transitional benefits are exhausted (typically, 6 to 12 months of medical benefits are available for those who leave welfare for work). However, there is concern and preliminary evidence that when a family is terminated from welfare, their Medicaid case is sometimes closed simultaneously, either because of state administrative errors or because recipients are unaware of the new eligibility rules or consider it too difficult or burdensome to submit a separate Medicaid application — especially if the demands of a job compete with the application or recertification process.[12] For example, Medicaid administrative data from California and Florida indicate that at least half of those leaving welfare lose their Medicaid coverage as well (Ellwood and Lewis, 1999). Garrett and Holahan (1999) found that, within one year after leaving welfare, only about 25 percent of the women and 50 percent of the children retained Medicaid, reflecting child-adult differences in eligibility for Medicaid; about one-half of the women and one-third of the children became totally uninsured.[13]

In summary, a number of recent policy changes have the potential to affect poor families' access to food stamps, Medicaid, and cash assistance, which could in turn have implications for their health and health care access. At the same time, health-related issues have implications for the success of the new policies.

III. Research Questions and Analytic Approach

A. Key Research Questions and Rationale

The literature linking health outcomes to socioeconomic indicators is substantial and consistent, indicating that people at the high end of the social hierarchy enjoy considerably better health and longevity than those at the lower end (see, for example, the review by Adler et al., 1994). There is also ample evidence that health problems are prevalent among welfare recipients (Loprest and Acs, 1996; Meyers, Lukemeyer, and Smeeding, 1996).

---

[12] In a recent national survey of parents of children eligible for Medicaid, 44 percent of those with uninsured children who had failed to apply said that the enrollment office was not open when they were able to go there. Over half of those eligible (58 percent) did not try to enroll their children because they did not think they would qualify. Furthermore, over 70 percent of parents of both Medicaid-enrolled children (72 percent) and eligible uninsured children (79 percent) thought that the welfare reform time limits also apply to Medicaid enrollment (Perry, Kannel, Valdez, and Chang, 2000).

[13] However, there is some preliminary evidence from Cuyahoga County (Cleveland) that the percentage of former recipients maintaining Medicaid (and food stamp) benefits after they exit the TANF program is increasing (Coulton et al., 2000), suggesting that recipients and/or caseworkers are becoming better informed about eligibility rules. Moreover, a recent (April 2000) directive from the Health Care Financing Administration has instructed states to identify people who have been improperly terminated from Medicaid and to reinstate them. Quint and Widom (2000) present information on improvements that are being made in the Urban Change sites; however, the initiatives described in that paper were not in place when the 1998-1999 survey data for the present report were collected.

The evidence about the relationship between socioeconomic status (SES)[14] and health generally suggests that the relationship is monotonic; that is, the higher a person's SES, the lower the prevalence of a wide range of health problems and early mortality (see, for example, Marmot, Kogevinas, and Elston, 1998; Pappas, Queen, Hadden, and Fisher, 1993; Smith and Egger, 1992). Thus, *even among low-income families*, it would be expected that systematic differences in health are associated with family resources. However, studies have generally compared families living in poverty with more affluent families; they have not often focused on health variations among disadvantaged families in general and welfare families in particular. The present report will fill an important gap in the literature about the health problems of people receiving welfare in a time-limited environment. The report focuses on a description of the health-related living conditions, physical and mental health outcomes, and health care of women who were at different points in the hoped-for trajectory between welfare receipt and self-sufficiency. The report addresses questions about the extent to which that expected trajectory is consistent with the life circumstances of the recipients.

Because of the recent landmark changes in welfare policy that could have implications for the health and well-being of poor families — and because health problems affect the implementation and success of that policy — there is a pressing need for timely information regarding the health status, health behaviors, health care access, and health insurance of those most likely to be affected. Accordingly, this report will address the following overarching question:

> *What are the health situations of welfare recipients and former recipients living in large urban areas during this era of welfare reform?*

The survey and ethnographic data available from the Urban Change study at this point in time are cross-sectional — that is, collected at a single point in time. As a consequence, this report is primarily descriptive in nature, but it is richly descriptive of a highly vulnerable population. The data from the Urban Change project provide an opportunity to examine the life circumstances and health situations of some of the poorest urban families and to describe the assets, constraints, and risks that such families face as they approach the time limits.

For the purpose of the report, "health" is broadly defined to encompass such issues as hunger and food insecurity, housing insecurity, violence and safety, health problems and health behavior, mental health, drug and alcohol use, domestic violence, access to and use of health care services, and health insurance. Child health outcomes are also described. This broad definition of health is consistent with that adopted by Healthy People 2010 (the national initiative for establishing and monitoring health priorities for the upcoming decade), which has emphasized the need to monitor not only disease and mortality but also the determinants of health: "Health status can be measured by birth and death rates, life expectancy, quality of life, morbidity from specific diseases, risk factors, use of ambulatory care and inpatient care, accessibility of health personnel and facilities, financing of health care, health insurance coverage, and many other factors" (U.S. Department of Health and Human Services, 2000a, p. 23).

---

[14] Socioeconomic status is a composite construct that typically incorporates economic status (income) and social status (educational attainment and occupation). The three indicators are correlated but not completely overlapping. Nevertheless, associations with health have consistently been observed for all three indicators.

In addition to an overall description of health outcomes in poor urban families, this report examines certain factors that account for variation in health and health care within the Urban Change population. In particular, this report for the first time examines health in four important subgroups defined on the basis of the women's employment[15] and welfare status at the time of the survey interview. The four work/welfare subgroups are

- women who had left welfare and were working (the work-only group)
- women who were combining work with welfare (the work-and-welfare group)
- women who were receiving welfare and did not work (the welfare-only group)
- women who had left welfare and were not working (the no-work, no-welfare group)

Each of these groups poses distinct challenges to policymakers and welfare staff in relation to both safety net services and strategies for leaving and remaining off welfare in a time-limited environment. Recipients' health concerns need to be taken into consideration with regard to both policy areas. Given TANF's work activity requirements, which become more stringent over time,[16] information about the link between health and employment among low-income mothers could be valuable in understanding possible obstacles to (or consequences of) employment.

Although health outcomes and employment status have consistently been found to be correlated, the relationship appears to be complex. Health problems (of both mothers and their children) are clearly a barrier to regular employment and to entry into the labor force, both in general and among welfare recipients (Riccio, Freedman, and Harknett, 1995; Hershey and Pavetti, 1997; Zedlewski, 1999). Thus, it is not surprising that employed women have repeatedly been found to be healthier than nonemployed women (see, for example, Bird and Fremont, 1991; Ross and Mirowsky, 1995; Waldron and Jacobs, 1989), with longitudinal data suggesting that health problems influence employment status (for example, Yelin and Trupin, 1999).

Researchers have also studied the possible effects that employment has on health. The evidence to date is not entirely consistent but tends to suggest that the net effect of employment on women's health is *not* negative, on average, and may be positive for certain women (Waldron and Jacobs, 1989; Yelin and Trupin, 1999; Ross and Mirowsky, 1995). However, it is important to note that the literature does not appear to have addressed whether women who lose health insurance coverage when they enter the labor force are negatively affected by employment as a result of diminished access to health care.

---

[15] For the purposes of this report, women's employment status was based on whether they reported being currently employed for pay at the time of the interview, regardless of whether the job was temporary or long-term, part-time or full-time. In recognition of the fact that there is considerable instability in the employment and welfare status of some poor women, alternative methods of defining the research groups were explored. This issue is discussed in Appendix B.

[16] In 1997, 25 percent of all recipients were required to participate in work-related activities for 20 hours per week. By 2002, however, 50 percent of the caseload will be expected to participate for 30 hours per week or more in an approved work-related activity.

In the present study, which is based on cross-sectional data, it will not be possible to draw definitive conclusions about the direction of influence between health and employment if such a relationship emerges. Nevertheless, several aspects of the study make it possible to make some tentative inferences about the nature of observed relationships. In particular, by controlling analytically for various background characteristics, it will be possible to rule out some competing explanations for observed results. Moreover, understanding of the link between health and employment will be enhanced through analysis of the rich ethnographic data.

While causal modeling techniques were not undertaken for this primarily descriptive report, it should be noted that an overall heuristic model, based on the research literature, guided both the conceptualization of the analyses and the organization of the written material. Figure 1.1 presents the model, which also indicates relevant chapters for broad content domains. Note that this model is simplified and fails to include numerous variables known to play a role in health and in employment. For example, health is known to be affected by health behaviors, genetic factors, and so on, and these are not shown in the model. Likewise, employment (versus welfare receipt) is affected by education, by the economy, and so on. Thus, the diagram only shows presumed links among variables covered in this report. According to this model, material hardships such as hunger or unsafe living conditions (which are affected by family income) have effects on mothers' physical and mental health and on the health of their children. Family health, in turn, is presumed to affect whether the mother is able to work and leave welfare. At the same time, employment can have reciprocal — though less direct and probably weaker — effects on health through its influence on family income. Employment and welfare status are also presumed to have implications for health insurance and health care access. Better access to health care is assumed to affect utilization of health care — as do the health problems of both mothers and their children. Health care utilization, then, is seen as having reciprocal, direct effects with health status: Illness and health problems lead to higher utilization, but utilization of health care leads to improvement in health. Again, it must be emphasized that the model in Figure 1.1 is not directly tested in this report, although the concluding chapter considers the evidence for some of the presumed links.

In closing, it should be noted that site differences in health outcomes were also explored. While there were significant site differences on many outcomes, there were few coherent patterns with respect to health status. That is, no one site stood out as having worse-than-average (or better-than-average) results across all or even most health outcomes. The major exception is that women in Miami, where welfare exits were especially prevalent, were more likely than women in other sites to be uninsured and to have health care access problems.[17] Appendix C summarizes the major site differences in terms of sample characteristics and health outcomes.[18]

---

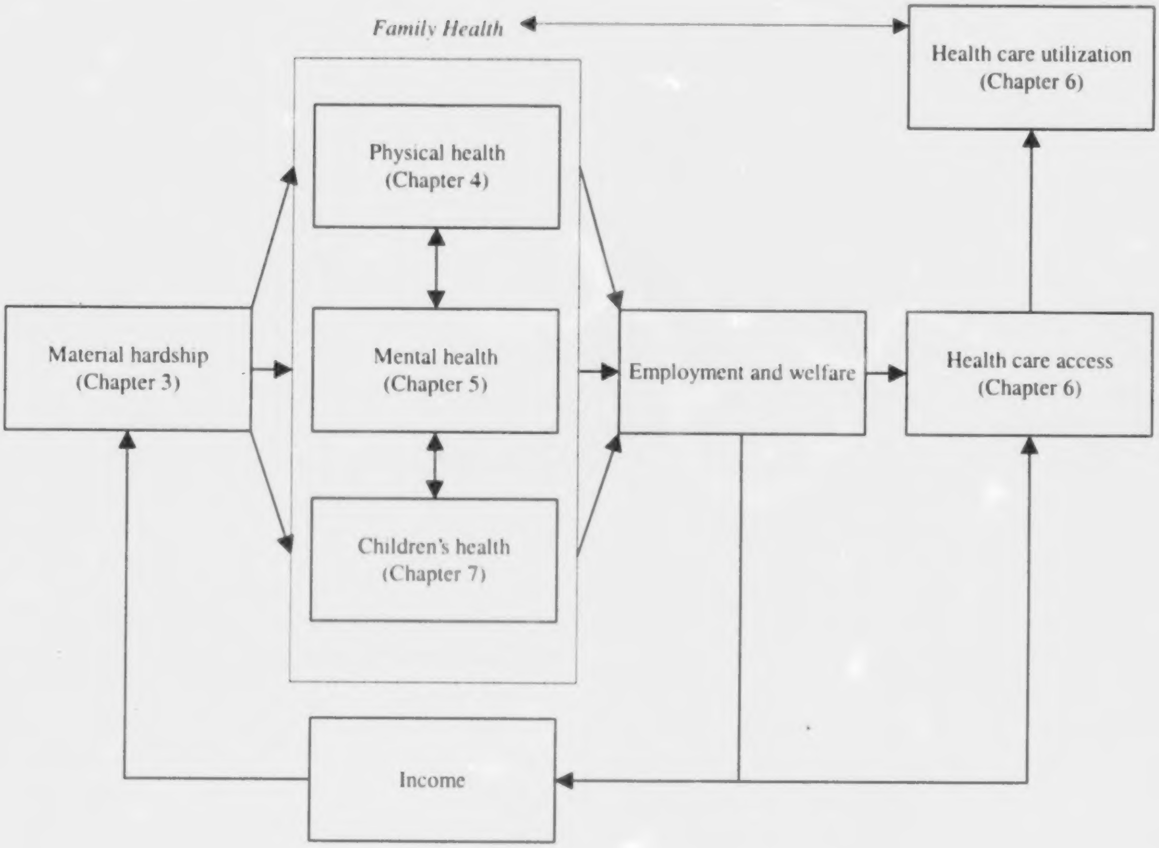
[17] Welfare leavers in Miami had the highest uninsured rate of any site, among both U.S. citizens and noncitizens. However, in all sites with immigrants, citizens who left welfare were more likely than noncitizen leavers to have health insurance.

[18] Future reports will provide in-depth information about the welfare reform stories in each of the four Urban Change sites.

The Project on Devolution and Urban Change

Figure 1.1

Heuristic Model of Health Outcomes in This Report


Family Health
Health care utilization (Chapter 6)
Physical health (Chapter 4)
Material hardship (Chapter 3)
Mental health (Chapter 5)
Employment and welfare
Health care access (Chapter 6)
Children's health (Chapter 7)
Income

B. Data Sources and Analytic Strategy

As noted, this report is based primarily on two data sources from the Urban Change project. First, survey data from the first (1998-1999) round of client interviews with 3,771 former or current welfare recipients were analyzed. For the purposes of this health report, only women who had received cash welfare benefits at some point in their lives (95.2 percent of those surveyed) were included in the analyses. The women in the full survey sample who met sample eligibility criteria on the basis of food stamp (rather than welfare) receipt in May 1995 were excluded so that the two nonrecipient research groups (that is, women in the work-only group and in the no-work, no-welfare group) would all be welfare leavers rather than a combination of former recipients and never-receivers of welfare.[19] Second, the report draws on narrative data from the first round of ethnographic interviews with 171 women in the four sites, most of whom were nonemployed welfare recipients in 1997-1998, when they were interviewed.[20]

Because of the primarily descriptive nature of this report, the numbers presented in the tables summarizing survey group differences are shown without any statistical adjustments. However, it must be noted that the four work/welfare research groups are composed of women with sizable demographic differences, as will be discussed in Chapter 2. Therefore, all the health outcomes presented in this report were also analyzed in relation to the women's work and welfare status, with statistical controls for several background characteristics. In this manner, it was possible to better examine the extent to which health and health care outcomes were related to the *circumstances* of the women's work and welfare status, rather than reflecting the effects of extraneous characteristics that may have led them to rely on different income sources. The background characteristics that were controlled were all ones that "predate" and could influence the women's current labor force status; moreover, they are characteristics that have been documented as being ones that matter for health: race/ethnicity;[21] age, educational attainment, citizenship status, presence of children under age 6 in the household, number of children in the household, and whether the woman was living with a husband or partner. The site and time elapsed between May 1995 and the interview date were also controlled.[22]

For the vast majority of health outcomes, work/welfare group differences that were statistically significant without regression adjustments remained significant even after these controls were introduced. Each table has a footnote indicating which, if any, group difference was no longer significant after adjusting for these background characteristics. Appendix E presents full regression models for selected health outcomes, and it summarizes the effects of the background characteristics on those outcomes.

---

[19] In future reports, the full Urban Change sample will be used to analyze trends over time (that is, changes between the 1998 and 2001 survey waves). Appendix D presents information about those women in the first survey sample who had never received welfare, comparing them with ever-receivers of welfare — those on whom the analyses in this report were based — for selected background characteristics and health outcomes.

[20] By the second round of ethnographic interviews, all four of the work/welfare subgroups were represented in the ethnographic sample.

[21] Race and ethnicity have well-documented associations with health outcomes. In the Urban Change survey sample, however, in which over 90 percent of the sample are minority group members, racial/ethnic differences were not substantial once other characteristics were simultaneously controlled (see Appendix E).

[22] Time elapsed was controlled because the survey fieldwork was completed over a 13-month period, during a time when there were welfare and food stamp caseload declines and a continued strengthening of the economy. Additionally, because the more easily locatable (and presumably less disadvantaged) women tended to be interviewed earlier in the fieldwork, the "time elapsed" variable could capture important unmeasured variation in health determinants.

Ethnographic data were analyzed using manual content analytic approaches designed to identify important themes emerging from the data. These analyses were expected to serve three purposes: (1) enrich the description of the health of poor, single-parent, urban families; (2) enhance the interpretability of the survey findings; and (3) provide new insights that could not be gleaned from survey data.

IV. Structure of This Report

The next chapter (Chapter 2) presents basic information about the Urban Change study sites and about the characteristics of the survey sample, including characteristics of the four work/welfare research groups. Integrated survey and ethnographic findings are presented in chapters corresponding to important substantive health issues. As shown in Figure 1.1, Chapter 3 examines the health-related material hardships of low-income urban women, including such hardships as hunger and food insecurity, problems with housing safety and quality, housing insecurity and homelessness, and residence in dangerous or undesirable neighborhoods. The subsequent two chapters (4 and 5) summarize findings on the health status of the survey and ethnographic samples. Chapter 4 focuses on self-reported physical health status and health behaviors such as smoking. Chapter 5 deals with mental health issues, including stress and depression, substance abuse, and domestic violence. Chapter 6 presents the findings relating to health care access and insurance coverage for the women and their families, and their health care expenditures and utilization. Child health outcomes in the Urban Change samples are described in Chapter 7. Chapter 8 focuses on the issue of multiple health problems that are potential barriers to employment — and to compliance with participation requirements — and examines these barriers in relation to the women's experiences as workers (for example, wages, benefits) and as welfare recipients (for example, sanctions). Chapter 9 summarizes the findings and presents some of their implications for public policy, including implications relevant to the deliberations on the reauthorization of PRWORA, scheduled for 2002.

Chapter 2

Overview of the Urban Change Sites and the Survey Sample

This chapter provides context for the remaining chapters of this report by presenting descriptive information about the Urban Change sites, including information about selected welfare and related policies that were in effect when the survey and ethnographic data were collected. Major background characteristics of the respondents in the Urban Change survey and ethnographic samples are also described.

I. Description of the Urban Change Sites

A. Demographic Portraits

The four counties participating in the Urban Change study are among the most populous in the United States, ranking from number 1 (Los Angeles County) to 17 (Cuyahoga County [Cleveland]) in 1990. Trends over time indicate that the populations in Cuyahoga and Philadelphia Counties are on the decline, whereas Miami-Dade and Los Angeles Counties are among the fastest-growing in the United States.

The four urban counties have considerable ethnic diversity but show different ethnic patterns. The majority of residents in Cuyahoga and Philadelphia Counties are white, but African-Americans represented 25 percent and 39 percent of the populations, respectively, in 1990. Los Angeles and Miami-Dade, by contrast, have large populations of both native-born Hispanics and immigrants from Spanish-speaking countries (38 percent and 49 percent, respectively, in 1990). Just under one-third of the residents in Los Angeles County were foreign-born at this time, while 45 percent of those in Miami-Dade were immigrants.

All four of the sites are characterized by high rates of poverty. In 1993, when the national poverty rate was 15 percent, poverty rates in the Urban Change counties ranged from 18 percent (Cuyahoga) to 27 percent (Philadelphia). In every site except Cuyahoga County, the unemployment rate in 1997 exceeded the national average.

B. Welfare and Related Policies

Under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), states have great latitude in designing their own policies relating to welfare, food stamps, and medical assistance. For example, states can change welfare grant levels and place more stringent time limits on clients' receipt of cash aid than the five-year limit mandated by the federal legislation. States also make decisions regarding clients' work and participation requirements; monetary incentives to encourage clients to work; criteria for exemptions from the time limits; receipt of transitional services such as child care and medical assistance after welfare exit; eligibility criteria for immigrants' receipt of services; and eligibility criteria for Medicaid and the Children's Health Insurance Program (CHIP).

As a consequence, each state now runs its own individualized welfare program, and, in some states, authority has devolved to local welfare agencies. Recipients in the four sites selected for the Urban Change project are subject to substantially different rules, procedures, and programs. Table 2.1 summarizes, for the states where the Urban Change sites are located, the key features of the welfare and medical assistance policies that were *in effect in 1998-1999* — that is, during the period when the Urban Change data used in this report were collected. At that time, the most generous program was in the California site (Los Angeles), where the five-year time limit for receipt of cash aid applied only to the adults on a welfare case, not to the children. Additionally, of the four Urban Change sites, Los Angeles had the highest income eligibility limits for adults receiving Medicaid and for children receiving CHIP coverage, as well as the largest cash grant ($565 for a family of three — the seventh-highest grant in the country in 1998).[1] For qualified noncitizens who immigrated after the enactment of PRWORA, California was, in 1999, one of only two states to have state-funded "substitute" programs for four federal safety net programs: cash welfare, medical assistance, food assistance, and disability assistance (Zimmermann and Tumlin, 1999).[2]

Florida, by contrast, had the most restrictive policies of the four sites — and also began its welfare reform program earliest, so that time limits went into effect sooner there than in other sites. The Miami site has a four-year lifetime time limit for receiving cash benefits. Additionally, recipients in Florida are restricted to receipt of cash benefits for no more than 24 months out of any five-year period (36 months if they are long-term recipients or meet other criteria). Thus, some recipients in the Miami site have already reached interim time limits.[3] Florida also had the lowest grant level of the four sites (it ranked thirty-sixth in the country) and low income eligibility limits for Medicaid receipt by adults. Finally, Florida, which has a sizable population of noncitizens, had no state-funded cash or medical assistance program in 1998-1999 for qualified immigrants who entered the United States after August 1996.

Ohio (Cleveland) and Pennsylvania (Philadelphia) had welfare policies that fell between those in California and Florida, with the Ohio program tending toward greater restrictiveness and the Pennsylvania program being somewhat more generous. For example, Ohio has established a time limit of three years, after which time recipients become ineligible for a minimum of 24 months, while Pennsylvania has adopted the federal time limit of five years. Ohio also terminates Medicaid coverage to sanctioned recipients of Temporary Assistance for Needy Families (TANF) after a third sanction for failure to comply with participation requirements, and there is a food stamp sanction for adults not complying with participation requirements.

---

[1] In 1998, California also had the most favorable "Medicaid generosity" rating of the four sites, based on a scale developed by the Urban Institute. Among other factors, the scale captures state eligibility expansions beyond federally mandated populations and the percentage of the population who are below 200 percent of the poverty level and eligible for Medicaid. The scale ranges from 1 ("most generous") to 8 ("least generous"). The ratings in the four states were as follows: California, 4; Pennsylvania, 5; Florida, 6; and Ohio, 8 (Zimmermann and Tumlin, 1999). However, since the ratings were made, all four states have made efforts to improve certain aspects of their Medicaid program.

[2] Except for certain categories of exempt immigrants (for example, refugees), qualified immigrants (those who are lawful permanent residents) who entered the United States after August 22, 1996, are barred from federal means-tested programs for their first five years in the United States.

[3] At the time of the survey, none of the respondents in the sample had reached the end of her time limit without receiving an extension. Recipients in Miami were not terminated as a result of reaching the time limits until October 1999.

61

Table 2.1

Selected Characteristics of Welfare Reform Initiatives and CHIP Programs in Effect in 1998-1999 in the Four Urban Change Sites

Provision	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Lifetime time limit on cash welfare for most families (start date of limit)	3 years (10/97)[a]	5 years (adults only) (1/98)	4 years (10/96)	5 years (3/97)
Exemptions from time limit[b]	None yet established	Disabled parent; those caring for disabled household member; domestic violence victims	Disabled parent; those caring for disabled household member	None yet established
1998 TANF benefit level, family of 3 (state rank) ($)	362 (29)	565 (7)	303 (36)	421 (22)
Age-of-child exemption from participation requirements	Single parents with child under 6 months	Parents with child under 1 year	Single parents with child under 3 months	Single custodial parent with child under 1 year;[c] parents caring for child under age 6, without child care
Pregnancy exemption from participation requirements	No	If pregnancy precludes work	No	No
Family cap provision[d]	No	Yes	Yes[e]	No
Sanctions if children not immunized	No	Yes	Yes	No[f]
Full-family sanction[g]	Yes	No	Yes	Yes[h]
Adoption of Family Violence Option[i]	No[j]	Yes	Yes	Yes

(continued)

Table 2.1 (continued)

Provision	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
State-funded programs for qualified immigrants after 8/96 during 5-year ban:[k]				
TANF/cash benefits	No	Yes	No	Yes
Food assistance	Yes	Yes (as of 10/99)	No (as of 10/98)	No
Medicaid	No	Yes	No	Yes
Transitional Medicaid (months)	12	12	12	6[l]
Income eligibility limits for single parents receiving Medicaid,[m] 1998 ($)	11,664	21,456	9,648	9,618
Medicaid coverage terminated for TANF sanction	Yes (for 3rd sanction)[n]	No	No	No
Upper eligibility for CHIP as percentage of federal poverty line[o]	150	250	200	200
Food stamp penalty for TANF sanction	Yes[p]	Yes[p]	Yes[q]	No

(continued)

SOURCES: MDRC calculations from the Urban Change Respondent Survey; Quint et al., 1999; State Policy Documentation Project, 2000 (www.spdp.org); Zimmerman and Tumlin, 1999; Tom Brock, personal communication; Raphael and Haennicke, 1999; Families USA Foundation, 1999; Health Care Finance Administration, 2000 (www.hcfa.gov); and People's Guide (www.peoplesguide.org).

NOTES: [a]After receiving benefits for 36 months, a family is ineligible for 24 months. After that period, if the agency determines that good cause exists, the family may be eligible for an additional 24 months.

[b]Exemptions refer to circumstances when a month of assistance does not count for purposes of the time limit. The table does not list all exemption criteria but only those in place as of October 1999 *that were relevant to the Urban Change population* (for example, California also grants an exemption for elderly caretakers who are age 60 or older).

[c]For a maximum of 12 months, lifetime.

[d]A family cap entails the partial or full denial of cash benefits to a child conceived while the mother is on welfare.

Table 2.1 (continued)

[e] For children born within 10 months of initial welfare receipt, the policy provides "limited" additional benefits: 50 percent for the first child and no benefits for each additional child.

[f] Although sanctions for school attendance and immunization are included in the state plan, regulations for these provisions have not yet been developed.

[g] The family's entire cash grant is withheld until the adult regains compliance.

[h] Before an adult reaches 24 months of welfare receipt (the "work-trigger" time limit), only the adult is sanctioned for noncompliance. After the 24-month point, the entire family is sanctioned.

[i] The Family Violence Option (based on the Wellstone-Murray amendment of PRWORA gives states the option to waive work requirements for victims of domestic violence.

[j] Counties in Ohio have the option of offering limited relief to domestic violence victims.

[k] Except for exempt immigrants (for example, refugees), immigrants who are lawful permanent residents and entered the United States after August 1996 are barred from federal means-tested programs for five years after entering.

[l] Six months of medical coverage is available, regardless of income; up to 12 months of medical coverage is available for households whose earned income is at or under 185 percent of the federal poverty level ($13,650 for a family of three in 1998).

[m] Annual income limits are based on a family of three with one wage-earner. These state income limits take into account earnings disregards for parents receiving Medicaid who have worked for 12 months or more. Income limits assume that earnings are the only source of income and that recipients are single-parent families.

[n] The recipient (but not her children) is terminated from Medicaid when facing a third sanction (unless pregnant); Medicaid benefits can be regained after compliance with TANF rules.

[o] Policies were in effect from October 1998 to September 1999. In 1998, the federal poverty level for a family of three was $13,650.

[p] The adult loses food stamps for one month for the first sanction, for three months for the second sanction, and for six months for the third sanction.

[q] The entire family loses food stamps for one month for the second sanction and for three months for the third sanction.

Table 2.2 shows that the four Urban Change states also differed with regard to changes in welfare, food stamp, and Medicaid caseloads. Between August 1996 (when PRWORA was passed) and August 1998 (roughly the time when the Urban Change survey data were being collected), state caseloads across all states declined, but declines in Florida were especially steep (53.6 percent). California, which had by far the largest caseload in 1996, had the lowest rate of decline of the four states (24.4 percent). It should be noted that the patterns of decline in welfare caseloads at the county level are similar to statewide patterns; that is, declines have been sharpest in Miami-Dade County and smallest in Los Angeles County. However, consistent with the fact that caseloads in large urban areas are not shrinking as quickly as elsewhere, in all four sites the county declines lag well behind statewide figures.[4] And, as indicated in Table 2.2, the four urban counties have disproportionate shares of their state's welfare caseload, and their shares are growing.

Table 2.2 also shows that both food stamp and total Medicaid participation rates also declined in all four states, but not in a pattern that paralleled declines in cash assistance. California (and Ohio) had the sharpest food stamp declines, yet California had the smallest change in the total number of nonelderly Medicaid cases.

Health outcomes for the four Urban Change sites are examined in Appendix C of this report, and these analyses suggest that state policies do have some implications for health outcomes.[5] In brief, women in Miami, where declines in welfare caseloads were sharpest, were most likely to have exited welfare and were most likely to have health care access problems, such as a lack of health insurance.

C. Health-Related Characteristics of the Sites

Table 2.3, which is based on data from the Neighborhood Indicators component of the Urban Change project, presents selected health characteristics of residents in the four Urban Change sites in 1996. For each of the six characteristics, the table presents information both for the entire county and for the specific census tracts from which the Urban Change survey sample was drawn.[6] Generally speaking, of the four sites, the residents of Philadelphia County had the highest percentage of health-related problems; they had the highest rates of infant death, low-birthweight infants, teenage births, suicides, and homicides. Of the four counties in the study, Los Angeles had the lowest rates on these health measures, with the exception of the homicide rate.

As might be expected, however, given the sampling criteria for this study, there was generally a higher prevalence of health problems in the census tracts from which the survey sample was drawn than in the counties overall. In some cases, the within-site differences were substantial. For example, the homicide rates in some sites were more than twice as high in the selected census tracts than in the county overall (for example, 25.5 and 8.9 per 100,000 population, re-

---

[4] Between 1994 and 1999, county and state welfare declines were as follows: Cuyahoga County, 45.8 percent, Ohio, 57.5 percent; Los Angeles County, 23.8 percent, California, 28.7 percent; Miami-Dade County, 51.6 percent, Florida, 67.1 percent; and Philadelphia County, 36.2 percent, Pennsylvania, 49.6 percent (Allen and Kirby, 2000).

[5] A recent paper examined variation in state welfare policy in relation to declines in state health insurance. It was found that diversion policies that were designed to deter would-be applicants from applying for welfare benefits were associated with Medicaid declines and with increases in being uninsured (Chavkin, Romero, and Wise, 2000).

[6] As explained in Chapter 1, the survey was drawn from census tracts in which either the poverty rate exceeded 30 percent of households or the welfare rate exceeded 20 percent of households.

The Project on Devolution and Urban Change

Table 2.2

Selected Information on Caseloads of States and Counties in the Urban Change Project

Characteristic	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Number of AFDC/TANF recipients (state), August 1996 (thousands)	549.3	2,581.9	533.8	531.1
State welfare caseload decline, 1996-1998 (%)	41.1	24.4	53.6	33.7
County's share of state welfare caseload, 1994 (%)	19.0	34.0	22.0	39.0
County's share of state welfare caseload, 1999 (%)	25.0	37.0	32.0	49.0
County's share of state population, 1999 (%)	12.0	28.0	14.0	12.0
Number of food stamp recipients (state), August 1996 (thousands)	988.0	3,076.1	1,356.1	1,088.3
State food stamp caseload decline, 1996-1998 (%)	30.7	30.7	29.8	19.4
Number of adult and children Medicaid enrollees, cash and noncash cases (state), 1997 (thousands)	793.1	3,830.2	995.9	945.1
Percentage decline in state Medicaid caseloads, 1995-1997 (%)	18.4	2.1	11.1	7.0

SOURCES: MDRC calculations from the Urban Change Respondent Survey and the Urban Change Neighborhood Indicators database; U.S. General Accounting Office, 1999, Table II.3; Ku and Bruen, 1999, Table 2; and Allen and Kirby, 2000.

The Project on Devolution and Urban Change

Table 2.3

Selected Health Care Characteristics of the Four Urban Change Sites, Countywide and Urban Change Survey Census Tracts

Characteristic	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Infant deaths per 1,000 births, 1996				
Countywide	10.0	5.9	6.0	12.1
Urban Change survey census tracts	16.1	5.6	8.2	15.2
Low birthweight babies as percentage of live births, 1996				
Countywide	9.3	1.2	7.7	11.7
Urban Change survey census tracts	13.5	7.1	10.6	13.7
Births to teenage mothers as percentage of live births, 1996				
Countywide	13.2	12.1	12.1	18.3
Urban Change survey census tracts	26.1	17.3	22.3	23.5
Percentage of mothers receiving late or no prenatal care, 1996				
Countywide	71.0	n/a[a]	79.6	66.5
Urban Change survey census tracts	52.2	78.3	64.7	61.1
Suicide rate per 100,000 population, 1996				
Countywide	10.2	10.2[b]	10.6	12.7
Urban Change survey census tracts	12.6	5.3	13.3	11.8
Homicide rate per 100,000 population, 1996				
Countywide	8.9	19.1[b]	15.0	26.4
Urban Change survey census tracts	25.5	28.3	30.5	41.9

SOURCES: MDRC calculations from the Urban Change Respondent Survey and the Urban Change Neighborhood Indicators database; Los Angeles Countywide data from the State of the County Report: Los Angeles 1998-99.

NOTES:

[a] Prenatal care data for Los Angeles County are not available at this time.

[b] Los Angeles County homicide and suicide rates are for 1995.

spectively, in Cleveland). In summary, then, the Urban Change sample was drawn from neighborhoods with higher-than-average health-related problems.

II. Description of the Urban Change Survey Sample

As noted in Chapter 1, much of this report is based on in-person interviews with a sample of 3,771 current or former welfare recipients in the four Urban Change sites. This section describes the characteristics of these women, who were interviewed in 1998-1999, as well as some characteristics of their children. It should be emphasized that the Urban Change survey sample is not a representative sample of welfare recipients or former recipients. The women in this sample were living in cities with high rates of poverty, and they were specifically sampled from neighborhoods that are among the poorest in those cities. However, as previously noted, in 1999 some 14 percent of all welfare recipients in the United States lived in the four counties included in this study.

A. Characteristics of Women in the Work/Welfare Groups

Most of the analyses in this report examine the relationship between health-related outcomes and the women's work and welfare status at the time of the survey interview. For the sample as a whole, one-third (33.0 percent) were in the work-only group, 16.6 percent were working and on welfare, 39.0 percent were nonworking recipients, and 11.4 percent had neither work nor welfare as an income source. This means that 29.9 percent of all current welfare recipients were employed at the time of the interview; this relatively high percentage of employed recipients presumably reflects the more generous financial incentives now in place to encourage recipients to work.[7] Among welfare leavers in the Urban Change sample (that is, the work-only group and the no-work, no-welfare group), 74 percent were employed.[8]

Figure 2.1 presents information about the distribution of the work/welfare research groups in the four sites. As this figure shows, women from Los Angeles were disproportionately likely to be in the two current welfare groups (69.0 percent), and those in Miami were least likely to be in either of these groups (45.1 percent). (However, Los Angeles had the highest percentage of current recipients who were working — 24.5 percent, compared with a low of 14.2 percent in

---

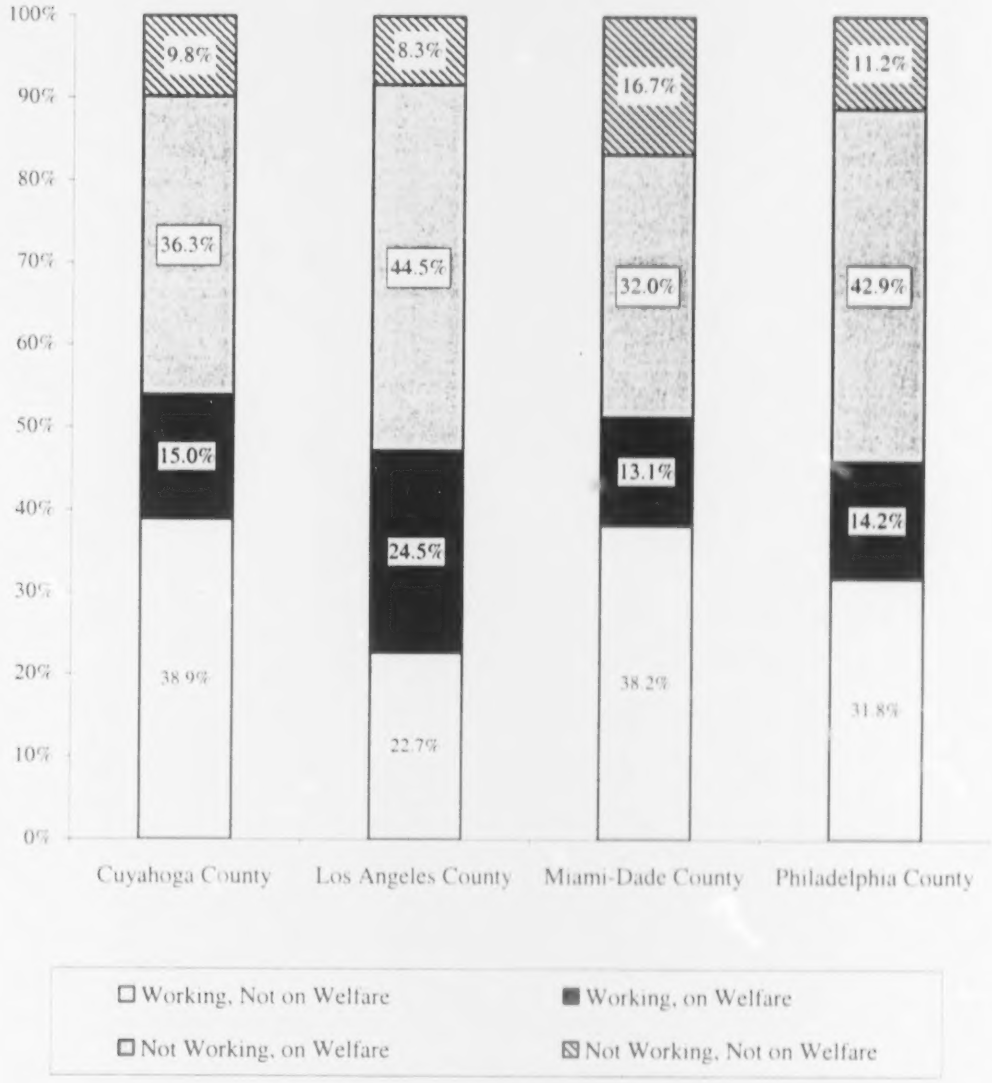
[7] State policies with regard to earned income that can be disregarded for the purpose of determining a recipient's eligibility and grant amount vary across the four sites. For example, in Philadelphia, 50 percent of earned income is disregarded; in the other three sites, the disregard is a fixed dollar amount (for example, $225 in Los Angeles) *plus* 50 percent of the remainder.

[8] This rate of employment is somewhat higher than has typically been reported in welfare leaver studies; for example, estimates of employment in the fourth quarter after exit ranged from 48 percent to 62 percent in 10 separate leaver studies (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2000). However, the higher rate in the Urban Change sample could reflect that fact that in the present study the timing of welfare exit was not fixed; for example, some leavers could have left welfare two or three years before the interview.

The Project on Devolution and Urban Change

Figure 2.1

Work/Welfare Status, by Site



SOURCE: MDRC calculations from the Urban Change Respondent Survey.

BEST COPY AVAILABLE

Philadelphia.) In Miami, twice as many women as in Los Angeles (16.7 percent versus 8.3 percent) were former recipients who were not working.[9] However, Miami (and Cleveland) also had the highest percentage of women who had left welfare and were currently employed. Site differences in the distribution of women in the four work/welfare groups were statistically significant. (Information about site differences in the women's background characteristics is presented in Appendix C).

Table 2.4 shows that, among the sample as a whole, most women are minority-group single mothers who had, on average, 2.4 children living with them at the time of the interview. Just under half the women had at least one child younger than age 6. Women in the sample ranged in age from 18 to 49, with an average age of 33.7. Nearly 70 percent of the women are African-American, and about 25 percent are Hispanic.[10] Almost half the sample (45.8 percent) lacked a high school diploma or equivalency certificate, compared with 12.4 percent of women age 20 to 44 nationally in 1999 (U.S. Bureau of the Census, 2000b). On average, in the month prior to the interview, the women in the sample had a total family income of $1,277 (including food stamp and welfare benefits but not the Earned Income Tax Credit, or EITC),[11] which translates to an annualized income of just over $15,000 per year.

The four work/welfare groups were different in a number of important respects, in addition to differences in their distribution by site. Table 2.4 shows that women in the two welfare recipient groups were substantially less likely to be married or living with a partner than women in the two welfare leaver groups.[12] Women still on welfare, working or not, also had more children (and younger children) than former recipients, and they were more likely to be pregnant. Taken together, the data suggest that women who continued to receive welfare had a greater burden of parental responsibilities than women who had left welfare.

While women in both working groups had better education credentials than those in the two nonworking groups, the women whose education backgrounds appear to be best suited to employment were, in fact, the women who had left welfare and were working. About 70 percent of these women (compared with half or less in the other three groups) had graduated from high

---

[9] Looked at the other way, 35 percent of the women in the no-work, no-welfare group were from Miami, compared with only 18 percent from Los Angeles. Some 36 percent of those who combined welfare and work were from Los Angeles, and 19 percent were from Miami.

[10] It should be noted that the ethnic distributions of the Urban Change sample do not reflect the ethnic distribution of the counties overall or of the county welfare caseloads, because the sample was selected from the poorest census tracts, where minorities are overrepresented. For example, in Cleveland approximately 47 percent of all welfare recipients are African-American, while in the Urban Change sample about 80 percent of respondents are African-American.

[11] Specifically, total family income in the prior month included income of all family members from any of the following sources: earned income; welfare benefits; food stamp benefits; child support; disability income (for example, Supplemental Security Income, or SSI); pensions; cash assistance from someone outside the household; and such other sources as unemployment benefits and rental income. Not included in the calculation were the EITC, housing subsidies, or the cash value of Medicaid or other health insurance.

[12] According to administrative records, in May 1995 none of the women was married; the sampling criteria specified that only single women were to be included in the survey sample. Some women undoubtedly got married between May 1995 and the date of the interview, but the administrative records for some women may also have been incomplete or erroneous.

The Project on Devolution and Urban Change

Table 2.4

Selected Characteristics of the Urban Change Respondent Survey Sample, 1998-1999, by Work and Welfare Status[a]

Characteristic	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Average age	33.7 ***	33.3	32.8	33.8	35.4
African-American (%)	68.3 **	66.9	72.2	69.5	62.1
Hispanic (%)	24.5 *	24.7	21.4	24.2	29.5
White, not Hispanic (%)	5.4 **	6.6	4.6	4.1	7.5
Not a U.S. citizen (%)	9.7	10.4	8.1	9.1	12.1
Married, living with spouse (%)	8.8 ***	14.4	2.7	3.6	19.2
Living with partner, unmarried (%)	10.1 ***	13.6	8.9	7.6	10.0
Average household size (%)	4.4	4.1	4.4	4.5	4.2
Average number of own children in household	2.4 ***	2.1	2.6	2.7	2.1
Has no children in household (%)	4.3 ***	5.0	1.4	2.0	12.5
Average age of youngest child	6.8 ***	7.3	6.1	6.2	7.9
Child under age 6 in household (%)	47.1 ***	42.7	53.0	50.6	39.3
Does not have diploma or GED (%)	45.8 ***	30.9	49.5	54.9	52.6
Has diploma or GED (%)	36.1 ***	42.5	33.8	32.2	34.0
Has some college credit (%)	18.1 ***	26.7	16.7	12.9	13.5
Ever employed, prior 12 months (%)	66.5 ***	100.0	100.0	27.3	38.2
Received welfare, prior 12 months (%)	67.7 ***	25.5	100.0	100.0	32.3
Average household income, past month[b] ($)	1,276.63 ***	1,732.65	1,391.04	935.86	1,014.96
Sample size	3,765	1,240	626	1,468	431
Percentage of sample	100	32.9	16.6	39.0	11.4

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Table 2.4 (continued)

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except that The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Total income of the immediate family includes food stamp benefits but does not include Earned Income Tax Credits (EITCs).

school or had a General Educational Development (GED) certificate. More than twice as many women in the work-only group (26.7 percent) as in the welfare-only group (12.9 percent) had some college credits. Women in the two groups of nonemployed women were more likely than working women to say they had problems conversing in English.

A noteworthy percentage of women in the welfare-only group (17.8 percent) said they had never worked for pay. However, substantial minorities of nonworking women (27.3 percent of those in the welfare-only group and 38.2 percent in the no-work, no-welfare group) had been employed at some point in the 12 months prior to the interview.[13] Similarly, many of the women not currently receiving welfare *had* received welfare at some point in the prior year: 25.5 percent of those in the work-only group and 32.3 percent of those neither working nor on welfare were fairly recent welfare leavers.

The four research groups differed considerably in terms of family incomes. The average total family income in the month prior to the interview for those in the work-only group was nearly twice as high as that for women in the welfare-only group. Annualized, their total family income in the prior month translates to an average of nearly $21,000 in the work-only group and just over $11,000 in the welfare-only group. Women in the no-work, no-welfare group had total family incomes only slightly better than those in the welfare-only group — an average of about $12,000 annually. Women who worked but received welfare were better off financially than recipients who did not work, with an average annualized total income of just under $17,000. Note that these figures include food stamp benefits but do *not* include the value of Medicaid for those receiving it.

In summary, despite the fact that virtually all the women in the Urban Change survey sample were economically disadvantaged, the four research groups nevertheless differed not only in terms of income sources but also in terms of credentials, circumstances, resources, and experiences, which could have implications for their health. In particular, women in the work-only group were substantially less disadvantaged than those in the other groups — and, especially, than those in the welfare-only and the no-work, no-welfare groups.

B. Employment Characteristics of Women Who Worked

The two groups of women who were working at the time of the interview had quite different employment experiences, as shown in Table 2.5. In general, women in the work-only group were in better employment situations than women who combined work and welfare.

Currently employed women had held their job from less than one month to over 20 years. On average, women in both groups had worked a fairly long time in their current job — 26.2 months. Although the two employed groups did not differ in average number of months in their current job, women who combined work and welfare were significantly less likely than those workers who had left welfare to have held their job for more than one year (39.5 percent versus 59.2 percent, respectively).

---

[13] As previously noted, the instability of the women's employment and welfare status was a concern in defining the four research groups. Appendix B addresses this issue and provides a rationale for the definition used.

The Project on Devolution and Urban Change

Table 2.5

Employment-Related Characteristics of Women Who Were Working at the Time of the Interview, by Welfare Receipt

Characteristic	All Working Women	Working, Not on Welfare	Working, on Welfare
Job longevity			
Average number of months at current job	26.2	25.7	22.8
Longevity in current job: less than 3 months (%)	16.6 ***	15.6	28.2
Longevity in current job: 3-12 months (%)	29.7 **	25.3	32.3
Longevity in current job: more than 12 months (%)	53.7 ***	59.2	39.5
Hours worked			
Average number of hours of work per week	35.1 ***	37.5	30.3
Works 30 hours or more per week (%)	72.1 ***	84.1	59.7
Hourly wage			
Average, before taxes ($)	7.62 ***	7.99	6.85
Less than $5.15 (%)	13.3 ***	9.5	21.0
$5.16 - $7.50 (%)	46.0 ***	43.1	52.0
More than $7.50 (%)	40.6 ***	47.4	26.9
Benefits of current job (%)			
Sick/personal days with pay	43.3 ***	53.0	21.6
Paid vacation	51.9 ***	61.4	30.6
Medical benefits for respondent	44.5 ***	54.7	21.6
Medical benefits for her children	34.9 ***	43.7	15.5
Training/tuition reimbursement	24.2 ***	31.1	9.1
No fringe benefits	45.0 ***	28.5	60.1
Schedule			
Maintains a fixed schedule at current job (%)	68.3 ***	72.6	59.7
Transportation			
Average number of minutes to commute to work	27.5	27.4	27.8
Uses public transportation to get to work (%)	33.8 ***	30.7	40.2
Drives own car to work (%)	39.6 ***	46.8	25.8
Sample size	1,866	1,240	626

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Table 2.5 (continued)

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

78

Although a majority of women in both groups were working full time (30 hours or more per week) at the time of the interview, working welfare recipients were less likely than working welfare leavers to have full-time jobs (59.7 percent versus 84.1 percent), and they were also less likely to have jobs with fixed schedules. The average hourly wage reported in the survey was $7.62 per hour, but working welfare recipients earned significantly less per hour than former recipients. About 20 percent of the working welfare recipients, compared with only 9.5 percent of the women in the work-only group, earned less than $5.15 per hour — the minimum wage when the interviews were conducted. Some 47.4 percent of the working welfare leavers (but only 26.9 percent of the working recipients) earned over $7.50 per hour in their current job.[14] Because of differences in both hours worked and hourly wages, the earnings of the two groups of working women differed considerably. In the month prior to the interview, the average reported earnings of working recipients was $605, while women in the work-only group had average personal earnings of $1,054.

The Work-Only Group

Most women in the work-only group (42.5 percent of the sample) were high school graduates. They tended to be single mothers with one or two, typically school-age, children. The majority were working full time in jobs that paid above the minimum wage and that offered at least one fringe benefit. Most women in this group had been working in their current job for more than 12 months. Their total annual family income from all sources was estimated to be about $21,000.

The Work-and-Welfare Group

Women who combined work and welfare (16.6 percent of the sample) were as likely *not* to have a high school diploma as to have one. These women are predominantly minority-group single mothers who were caring for two or more children; most had a preschool-age child living with them. Only about half had full-time jobs, and more than half were in jobs with no fringe benefits. Most acknowledged that they were subject to the welfare agency's work requirements. Their total family income in the month prior to the interview would translate to an annual income of under $17,000 per year.

---

[14] For a family of three, an hourly wage of $7.50 per hour in a 35-hour-per week job would be just at the 1998 poverty level ($13,650 annually).

Moreover, women in the work-only group were substantially more likely to be in jobs that offered fringe benefits. Overall, 55.0 percent of the working women had at least one fringe benefit; but former welfare recipients (61.4 percent) were substantially more likely than those still on welfare (30.6 percent) to be working in a job with benefits, including paid vacation and sick pay. More than twice as many working welfare leavers as working recipients had employer-provided medical benefits for themselves and their children. Nevertheless, despite the fact that a majority of women in the work-only group had been employed for over a year in their current job, only about half had employer-provided health insurance for themselves, and fewer than half (43.5 percent) had such insurance for their children.[15]

Both groups of working women reported that it took them an average of just under a half hour to get to work each day, but their modes of transportation differed. Overall, about one-third of employed women took public transportation, but those in the work-and-welfare group were especially likely to do so, while women in the work-only group were much more likely to drive their own car to work.

Overall, then, the women who worked and no longer relied on welfare had substantially better job situations than those who combined work and welfare — they had better-paying jobs; most had fixed schedules; and they were more likely to have such fringe benefits as sick pay, paid vacations, and health insurance.

C. Welfare-Related Characteristics of Welfare Recipients

The Welfare-Only Group

Most nonworking women who were still on welfare (39.0 percent of the sample — the largest group) were not high school graduates. They were almost all single mothers, and about half had three or more children, at least one of whom was a preschooler. Few had worked for pay in the prior year. Only about half reported that they were subject to the welfare agency's work or participation requirements. More than one out of four said they had been sanctioned by the welfare agency in the previous 12 months. This was the poorest of the four groups, with total family income in the prior month annualized to be, on average, about $11,000.

Welfare-related characteristics of the two groups of women currently receiving cash aid at the time of the interview were also examined, and these are shown in Table 2.6. More than half the recipients in the survey (55.3 percent) reported that they were subject to work or participation requirements as a condition of welfare receipt (or were working already and thought that this "exempted" them). Women who worked were significantly more likely to acknowledge this requirement (65.7 percent) than those who did not work (51.0 percent). The primary reasons re-

---

[15] Among those women who were working full time in jobs they had held for at least one year, 34.8 percent of the former recipients and 62.7 percent of the current welfare recipients did *not* have personal health insurance as a fringe benefit (not shown).

80

The Project on Devolution and Urban Change

Table 2.6

Welfare-Related Characteristics of Women Who Were Receiving Welfare at the Time of the Interview, by Employment Status

Characteristic (%)	All Welfare Recipients	Working, on Welfare	Not Working, on Welfare
Requirements and rules			
Is subject to work or participation requirements	55.3 ***	65.7	51.0
Ever sanctioned for not following welfare agency rules, past 12 months	29.8 **	33.8	28.1
Treatment by welfare staff			
Gets personalized attention from case manager	32.6	30.1	33.7
Pushed by welfare staff to get a job quickly	50.5	53.8	49.2
Urged by case manger to get education or training	33.8	34.7	33.4
Urged by case manager to bank months for later	14.8 **	18.0	13.4
Knowledge of new rules			
Knows medical benefits will continue if she leaves welfare for work	51.1	54.2	49.8
Knows there is a time limit for cash welfare benefits	75.5	75.7	75.4
Of those knowing time limit:			
Believes welfare agency will likely cut her off at time limit	89.7	91.6	89.0
Thinks time limit is fair	46.6	47.3	46.3
Started education/training because of time limit	38.1 ***	31.1	41.1
Took a job because of time limit, but preferred staying home	19.0 ***	28.2	15.0
Sample size	2,094	626	1,468

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

ported for their exempt status was their own health or the health of another family member (14.4 percent of recipients) and either being pregnant or having a young child (9.3 percent) (not shown). Recipients who did not work were more likely to report these exemptions than those who were working.[16]

About one-third of the women in both groups had had a sanction imposed for some type of noncompliance. Working recipients were somewhat more likely to say that they had been sanctioned at least once in the previous year for not following the welfare agency's rules — possibly reflecting their higher rate of having participation requirements that would expose them to sanctions.

Welfare recipients were asked about their treatment by welfare staff. About one-third of the women (both working and nonworking) felt that they got personalized attention from their case managers, and a similar percentage said that case managers urged them to get more education or training.[17] Just over half (53.8 percent) of the recipients said that the welfare agency had pushed them to get a job quickly, but women who worked were somewhat more likely to have said this. A higher percentage of the women who combined work with welfare (18.0 percent) than those who did not work (13.4 percent) also said that they had been urged to "bank" their months of welfare eligibility for later use (that is, to leave welfare and save their remaining months of eligibility), which is consistent with the fact that they would have been receiving reduced welfare checks as a result of their employment.

Current recipients were also asked about their knowledge of new welfare rules that came into effect as a result of PRWORA. Only about half the recipients knew that if they left welfare for work they would continue to be eligible for Medicaid as a transitional benefit; a slightly higher percentage of working women knew about transitional medical assistance. Most (but not all) recipients knew that there are now lifetime time limits for welfare receipt (76 percent).[18] Among those who knew about time limits, the vast majority (89.7 percent) believed that the welfare agency would, in fact, cut them off when they reached their limit, and approximately half thought that the time limit is fair. About 20 percent of the women who knew of the time limit said that they did not know how much time was left on their clock (not shown). Some women acknowledged that the time limit had affected their behavior, although the effects were different for the two welfare groups. Nonemployed recipients were more likely than those who worked to say that they had started an education or training program because of the time limit (41.1 percent versus 31.1 percent). However, employed women were nearly twice as likely to say that they had taken a job because of the time limit even though they would have preferred to stay home (28.2 percent versus 15.0 percent).[19] In summary, at the time of the surveys (1998-1999), not all women appeared to be aware of the particulars of the new welfare programs, but some of those who were aware had been prompted by the new policy to make changes in their lives.

---

[16] Many of the remaining women who reported that they were not required to participate in work-related activities indicated that they did not know why they were exempt (11.3 percent).

[17] Surprisingly, women who did not have a diploma or GED certificate were no more likely to report such encouragement than women who did.

[18] Welfare leavers in the work-only group were as likely as recipients to know about the time limit, but only 67.3 percent of women who were neither working nor receiving welfare knew about time limits. Fewer than half (about 45 percent) of the women in the two groups of former recipients said they knew about transitional Medicaid.

[19] Presumably the women who were not working but said they had taken a job because of the time limit meant that they had taken a job but then had either quit or were let go.

D. Characteristics of Women Neither Working nor on Welfare

The No-Work, No-Welfare Group

Women who were neither on welfare nor working (11.4 percent of the sample) were more likely to be married than women in the other groups, and they were also most likely not to have any children living with them. Additionally, their children tended to be older. The majority had not worked for pay at all in the prior year, and most had not collected any welfare benefits in that period. Only a small minority reported no source of income in the prior month. The most important income source was from the paid employment of another household member. This group was nearly as disadvantaged financially as the welfare-only group, with an estimated total annual income of about $12,000.

The group that is perhaps most difficult to characterize is women who had left welfare but who, at the time of the interview, were not working. The majority of women in this group (67.6 percent) had not received welfare at any time in the previous year, according to their self-reports; however, about one out of five (21.3 percent) said that they had reapplied for welfare in the previous 12 months and had been turned down (not shown in tables).[20]

As Table 2.7 shows, only a handful of women (4.1 percent of those in the "neither" group) said that they had *no* source of income in the month prior to the interview. Thus, women in this group had alternative sources of support, and these sources differed depending on whether the woman was married or not. Less than 1 percent of married or cohabiting women had no income in the prior month, compared with more than 5 percent of the women without partners.

For the no-work, no-welfare group overall, 17.7 percent reported that they had earnings from employment in the prior month, meaning that they had lost or quit a job within the past 30 days, and 8.6 percent had lost welfare benefits during the same period. Women who were not married were more likely than those who were married to have gotten income in the previous month from a pension (Social Security Administration, or SSA), cash welfare, or cash assistance from someone outside the household. For the group as a whole, the earnings of other household members was the most frequently cited source of family income, reported by 42.3 percent of

---

[20] In response to a question about why they had exited welfare, 31.1 percent reported leaving either because they got a job or because their earnings increased; women who had left in the past year were no more likely than those who had left earlier to cite this as the reason for their departure. (Note, however, that these women were no longer in the jobs that had resulted in their welfare exits.) Nearly one out of five (18.3 percent) women in this group indicated that they had left welfare because of a compliance issue; that is, they had failed to appear for an appointment, to participate in required activities, to turn in required paperwork, and so on. Recent leavers were far more likely to cite a compliance issue (31.8 percent) than women who had left welfare more than one year earlier (12.1 percent). By contrast, recent leavers were *less* likely than earlier leavers to say they had left welfare as a result of marriage or moving in with a partner — 4.5 percent versus 10.4 percent, respectively.

The Project on Devolution and Urban Change

Table 2.7

Income Sources of Women Neither Working nor on Welfare at the Time of the Interview, by Current Marital Status

Outcome, Month Prior to Interview (%)	All Other Women	Married or Cohabiting	Not Married or Cohabiting	All Women Neither Working nor on Welfare
No reported source of income	0.6 ***	0.9	5.4	4.1
Own sources of income				
Paid employment	54.2 ***	15.9	18.5	17.7
Cash welfare benefits	59.0 ***	3.0	11.1	8.6
Child support	10.2	12.1	15.5	14.5
Disability income, SSI	7.8 ***	10.6	18.2	15.9
Social Security, SSA	2.4 ***	3.8	9.1	7.5
Cash from others outside household	8.2 *	6.1	14.8	12.1
Income of others in household				
Paid employment	29.6 ***	72.7	21.2	42.3
Cash welfare	4.7	3.8	6.0	5.3
Disability income, SSI	7.4 *	7.6	11.3	10.1
Social Security, SSA	4.6 ***	5.3	12.0	9.8
Has money in savings	19.9 *	22.0	10.8	14.2
Sample size	1,026	149	364	513

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

these women. Those who were married were substantially more likely than those who were not to be in households where someone else worked (72.7 percent versus 21.2 percent). Married women in the no-work, no-welfare group were also much more likely (22.0 percent) than those who were not married (10.8 percent) to report that they had money in savings.

The income sources of women in the no-work, no-welfare group are compared with those of all other sample members in the far right column of Table 2.7. Almost all the differences are statistically significant. Women who had left welfare and were not working were more likely than other women in the sample to have disability income, a pension (SSA), and help from outside the household. They were also more likely to be living with household members who worked or who received disability or a pension. Thus, women who left welfare before the time limit and were not working were more likely than other women to have alternative sources of support — support, however, that resulted in total family incomes that were, on average, lower than those of women in the two working groups.

E. Characteristics of Children, by Mother's Work/Welfare Status

As reported in Table 2.4, the women in the survey sample had an average of 2.4 children living with them at the time of the interview. Mothers were asked a number of questions about their children, including health-related questions. (Chapter 7 describes the health outcomes for these children.) In addition to questions concerning all their children (for example, Have any of your children ever dropped out of school?), the survey included a series of questions about a specific focal child living in the household. Focal children were selected from two age groups thought to be of special interest with regard to work requirements: those younger than age 6 (that is, preschoolers who would need child care if their mothers worked) and those age 12 to 18 (that is, adolescents for whom supervision might be a special issue for working mothers).[21]

Table 2.8 presents some basic descriptive information about the younger and older focal children, according to their mother's work/welfare status. The preschool-age focal children were, on average, 4.6 years old, and they are about evenly divided in terms of gender. The majority of children in all four groups had a nonmaternal child care arrangement at least once a week,[22] but children whose mothers worked were significantly more likely to have nonmaternal care. Nearly one-quarter of the children whose mothers were in the work-only category, compared with only 5.2 percent of those whose mothers were in the welfare-only category, were currently in a formal child care arrangement such as center-based care, a nursery school, or a preschool program. Only a small minority of the young focal children (3.3 percent) had ever lived away from their mothers for one month or more, and the vast majority of mothers (94.8 percent) reported that they always or almost always knew where their children were when they were not at home; the four groups

---

[21] Approximately 21 percent of the sample had no focal children, 65.8 percent had one focal child (35.9 percent with a younger child, 30.0 percent with an older one), and 13.0 percent had two focal children — that is, a preschooler *and* an adolescent. In families with two children or more who met a focal-child age criterion, one child was randomly selected.

[22] Some children of nonworking mothers may have been in child care because their mothers were involved in activities to fulfill the welfare agency's participation requirements. Among women in the welfare-only group, 30.0 percent indicated that they were currently in an educational or work-related activity; 17.6 percent of those in the no-work, no-welfare group were in such an activity.

The Project on Devolution and Urban Change

Table 2.8

Selected Characteristics of the Focal Children in the Urban Change Respondent Survey Sample, 1998-1999, by Mothers' Work and Welfare Status[a]

Outcome	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Younger focal child[b]						
Average age	4.6		4.6	4.6	4.6	4.6
Male (%)	48.6		49.0	44.4	49.4	51.5
Currently in child care arrangement 1 day or more per week (%)	80.1	***	86.9	82.0	65.5	59.5
Currently in center-based care/nursery school (%)	11.4	***	22.1	12.1	5.2	2.4
Ever lived away from mother (%)	3.3		3.0	4.1	3.3	2.4
Mother almost always knows child's whereabouts (%)	94.8		94.5	96.8	93.8	97.0
Child sees father 1 time or more per week (%)	42.0	***	53.0	31.6	37.5	46.7
Father pays child support (%)	24.4	***	35.2	17.6	20.0	27.0
Number of children	1,839		563	340	769	167
Older focal child[c]						
Average age	14.5		14.4	14.5	14.6	14.7
Male (%)	49.9		47.3	50.9	50.9	51.4
Teacher contacted mother about school problems (%)	42.3	*	38.9	50.6	41.4	42.0
Child ever expelled or suspended from school (%)	22.6	*	19.7	27.5	29.0	23.5
Child ever been in trouble with the police (%)	7.0	***	3.1	7.7	8.7	9.5
Child ever had or fathered a baby (%)	3.6	**	1.5	4.4	5.2	2.2
Ever lived away from mother 1 month or more (%)	8.8		6.3	8.4	9.6	13.4
Mother almost always knows child's whereabouts (%)	76.3		76.4	75.8	76.4	77.1
Child sees father 1 time or more per week (%)	23.5	***	29.5	20.2	1[illegible].8	26.8
Father pays child support (%)	17.8	***	25.3	14.2	13.0	24.5
Number of children	1,617		478	273	687	179

(continued)

Table 2.8 (continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except that The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a]Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b]Younger focal children were selected from those children in the household age 6 or younger.

[c]Older focal children were selected from those children in the household between ages 12 and 18.

were similar in these respects. However, there were significant group differences relating to the children's biological fathers. Children of mothers in the work-only group were substantially more likely to see their fathers at least weekly than other children. They were also especially likely to have fathers who paid their mothers child support: 35.2 percent of children in the work-only group, compared with only 17.6 percent of those in the work-and-welfare group, had paternal child support.

Table 2.8 shows that the older focal children were, on average, 14.5 years old. Among those who were currently in school (about 94 percent of the older focal children),[23] 42.3 percent had teachers who had contacted the mothers to discuss academic or behavior problems in the previous 12 months. Mothers who combined welfare and work were especially likely to have had a teacher contact them about their adolescent child. Nearly one out of four of the older focal children had been suspended or expelled from school; children in the work-only group had the lowest rate (19.7 percent), and those in the welfare-only group had the highest (29.0 percent). According to the mothers, some of these focal children had been in trouble with the police (7.0 percent) or had already had or fathered a baby (3.6 percent). Children whose mothers were in the work-only group had the lowest rate of both these problems. Nearly 1 out of 10 of these children had lived away from their mother for at least a month at some point — most often because of the child's behavior problems (22.8 percent) or because of the mother's personal problems, such as drug abuse or alcoholism (12.1 percent; not shown in tables). About three-fourths of the mothers in all four groups said that they almost always knew where their adolescent children were when they were not at home, possibly suggesting that mothers who worked were not at a particular disadvantage in their ability to monitors their teenagers. As was true for the younger focal children, there were significant group differences relating to the older focal children's fathers. Adolescents whose mothers were in the work-only group were most likely to see their fathers at least weekly. Women who had left welfare (whether working or not) were about twice as likely as current recipients to get child support for their adolescent child.

In summary, the children in the four groups, like their mothers, had a number of noteworthy differences. The overall picture is that the children whose mothers had left welfare and were working had fewer problems than children in the other groups. However, it is important to note that these data do not tell us whether children had fewer problems because their mothers worked or whether working was more feasible for mothers whose children had fewer problems — or whether other factors influenced both employment and children's behavior.

III. Description of the Ethnographic Sample

Table 2.9 presents some basic demographic information about the 171 women who composed the baseline ethnographic sample. In terms of race and ethnicity, there are more white women in the ethnographic sample (18.7 percent) than in the survey sample (5.4 percent), reflecting the decision to include a white neighborhood in the ethnography in both Cleveland and Philadelphia. Overall, about half the ethnographic sample are African-American, and just over a

---

[23] Of the older focal children, 3.1 percent were dropouts who had not yet received a diploma. Adolescents in the four groups had similar dropout rates.

90

The Project on Devolution and Urban Change

Table 2.9

Characteristics of the Urban Change Ethnographic Sample, by Site

Characteristic	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Completed baseline interviews[a]	171	47	46	39	39
Race/ethnicity (%)					
White	18.7	38.3	n/a	n/a	35.9
African-American	49.1	61.7	26.1	46.2	64.1
Mexican-American	6.4	n/a	23.9	n/a	n/a
Mexican immigrant	7.6	n/a	28.3	n/a	n/a
Cuban immigrant	4.1	n/a	n/a	17.9	n/a
Dominican immigrant	1.8	n/a	n/a	7.7	n/a
Colombian immigrant	1.8	n/a	n/a	7.7	n/a
Puerto Rican[b]	2.9	n/a	n/a	12.8	n/a
Other Hispanic/Latino[c]	1.8	n/a	n/a	7.7	n/a
Cambodian	5.8	n/a	21.7	n/a	n/a
Immigrant to the United States (%)	22.2	0.0	54.3	30.8	2.6
Citizen of the United States (%)	81.1	100.0	50.0	78.4	97.4
Average age (in years)	33.2	31.1	33.1	35.3	31.5
Less than high school education[d] (%)	60.2	36.2	87.0	51.4	63.9
Currently married[e] (%)	24.1	23.4	43.5	7.7	15.8
Average number of children[f]	3.1	2.5	3.9	2.8	3.2
Any child less than 6 years old (%)	67.5	70.2	73.9	57.9	63.2
Reported work[g] (%)	16.5	25.5	15.2	5.1	15.8

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey and the Urban Change Neighborhood Indicators database.

NOTES: Most aspects of the design of the Urban Change ethnographic sample were implemented in each of the four sites. The design in Cuyahoga and Philadelphia Counties is identical; however, in Miami-Dade and Los Angeles Counties, the design was varied to include greater numbers of Hispanics/Latinos, immigrants, and Cambodian refugees.

N/a = not applicable.

[a] Numbers for some estimates vary because of missing data. In a small number of cases, women were enrolled in the study (that is, signed consent forms) but never completed the baseline interview. The sample excludes these women, because most of their data are missing.

Table 2.9 (continued)

[b] All the Puerto Rican women in the sample were born on the Island of Puerto Rico. These women were not counted as immigrants.

[c] Includes one Guatemalan immigrant, one Honduran immigrant, and one Cuban-American who could not otherwise be classified.

[d] Women who did not graduate from high school or receive a GED were counted as having less than high school education regardless of the amount of other training they received. This coding scheme was adopted because high school graduation or the equivalent is a credential that is relevant in the labor market.

[e] Includes a few women who were married but living apart from their spouses at the time of the baseline interview.

[f] Includes some grandchildren, nieces, nephews, and other children who were living in the household and were on the respondent's TANF grant at the time of the baseline interview.

[g] Includes only work that was reported to the welfare office. Many women who worked did not report it to their caseworker.

quarter (26.4 percent) are Hispanic, with varying Hispanic origins. A somewhat higher percentage of women in the ethnography (18.9 percent) than in the survey (9.7 percent) were noncitizens, again reflecting the deliberate decision to include neighborhoods with high concentrations of immigrants in the ethnographic samples in Miami and Los Angeles.

All the women in the ethnographic sample were welfare recipients at the outset of the study, and so it is most appropriate to compare them with the two groups of current recipients in the survey rather than with all survey sample members. The women in the ethnographic sample were similar in age to those in the survey (about 33 years old, on average). They were somewhat less likely to have a high school diploma or GED certificate than women in the two current-recipient survey groups (60.2 percent versus 45.8 percent). Women in the ethnography were substantially more likely to be married than survey respondents (24.1 percent versus 8.8 percent) and to have a preschool-age child (67.5 percent versus 47.1 percent).[24] Finally, fewer of the ethnographic welfare recipients (16.5 percent) than survey welfare recipients (29.9 percent) were working at the time of the first interview.

Thus, the survey and ethnographic samples had substantial demographic differences, although it is possible that survey respondents *from the neighborhoods included in the ethnography* would be more comparable. It should also be remembered that the selection criteria were different. In particular, all the welfare recipients in the survey were by definition long-term recipients, because they had been on the welfare caseloads in May 1995. The ethnographic sample likely had more women who had come onto the rolls more recently.

---

[24] It is not possible to compare the number of children in the two samples because the figure for the ethnographic sample includes not only the woman's children but also other children living in the household who were on her grant. The survey obtained information about other children living in the household but did not ask whose welfare grant they were on.

Chapter 3

Material Hardships: Food Insecurity, Housing Quality, and Housing Insecurity

I. Introduction

As previously noted, poverty has long been considered a public health issue, reflecting the fact that socioeconomic status (SES) has been found for hundreds of years to be negatively correlated with numerous indicators of morbidity and mortality in virtually all cultures (Link and Phelan, 1995, 1996; Lynch, 1996). There are various theoretical bases for explaining the mechanisms underlying this association, including (1) genetic determinants and self-selection, (2) health as the determinant of economic circumstances, (3) differential access to health care, and (4) the effects of socioeconomic factors on biological functions that influence health status.

In a seminal review of the literature, Adler and her colleagues (1994) noted that the association between health outcomes and socioeconomic status occurs at every level of the SES spectrum; that is, there does not appear to be a threshold above which (or below which) income or education do not matter to health status. They concluded that the evidence to date points to the dominance of the fourth explanation, namely, that social stratification and differences in income alter one's life course in ways that affect health.

Research suggests that society's role in shaping patterns of disease — the fourth explanation — occurs through its effects on various domains, including the following:

- material resources needed for adequate nutrition, hydration, and shelter
- the physical environment and the resulting exposure to pathogens, carcinogens, and other environmental hazards (for example, through improper sanitation, pollution, and so on)
- the social environment, including exposure to interpersonal aggression and violence
- exposure to experiences that cause stress and affect psychological development

This chapter examines such mechanisms, all of which relate to material resources and aspects of the physical, social, and psychological environment that have relevance to health outcomes.[1] Specifically, the chapter focuses on a range of material hardships that can affect health directly (for example, through hunger or exposure to allergens) as well as indirectly (for example, by contributing to stress and depression, which are associated with numerous health problems). These pathways are shown in the heuristic model in Figure 1.1 (Chapter 1).

---

[1] Socioeconomic factors can also shape health through their effects on health behaviors, which are discussed in Chapter 4. Stress and depression as health *outcomes* are addressed in Chapter 5. The current chapter focuses on factors that could contribute to stress.

Interest in the concept of material hardships was heightened in the late 1980s with the publication of a paper by Mayer and Jencks (1989) that criticized the exclusive use of official poverty statistics in capturing the distribution of deprivation in our society. Mayer and Jencks found that poverty and material hardship were correlated but that a family's income-to-need ratio[2] explained only about a quarter of the variance in material hardship. They argued that because government policy (and public opinion) tends to be more focused on reducing specific forms of material hardship (for example, food deficiencies) than on reducing poverty per se, it is important to measure material hardship regularly. Mayer and Jencks found that material hardships were significantly correlated with health.

While there is considerable evidence that income affects material hardship, there is relatively little information about factors that affect material hardship *within* a low-income population — or even to what degree there is variability. To the extent that employment improves family income, one might expect that low-income women who work would have fewer material hardships than welfare recipients.[3] But it should also be noted that any association between employment and material hardship could reflect reversed, or reciprocal, causation; that is, for some women, material hardships may precede and in part determine decisions about employment, even though employment itself may influence subsequent hardship.

Supporters of welfare reform expect that time limits for receipt of cash benefits, in conjunction with enhanced but temporary assistance, will promote self-sufficiency and improve the financial situation of poor families in the long run. In turn, improved finances are expected to translate into reduced material hardships. Critics of welfare reform, on the other hand, predict adverse effects on families — increased poverty, homelessness, and housing problems; loss of health insurance; and greater food insecurity and hunger. In short, critics predict *greater* material hardship to result from welfare reform.

This chapter examines a range of health-related material hardships in relation to the work and welfare status of a sample of disadvantaged urban mothers. It is important to emphasize, however, that because data for this report were collected before any time limits were imposed on Temporary Assistance for Needy Families (TANF) benefits, the findings offer no direct information about how welfare reform might ultimately affect material hardship among disadvantaged urban families.

II. Food and Nutrition

Food hardships in U.S. households have posed a persistent challenge to health, nutrition, and social policy. The central policy tool for improving the nutritional status of low-income families is the Food Stamp Program, authorized under the Food Stamp Act of 1964. Through several provisions in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), however, there have been sizable overall reductions in the calculation of food stamp benefits.[4] Food stamp expenditures are projected to decline by about $22 billion from 1997 to 2002, relative to what they would have been without welfare reform (Gunderson, LeBlanc, and Kuhn, 1999). These reductions are the direct and intended effects of PRWORA. But it appears that an unforeseen indirect effect of welfare reform is that some families who are eligible for food stamps leave the Food Stamp Program when they leave welfare, despite the fact that most former welfare recipients take low-paying jobs that leave them eligible for food stamps (Loprest, 1999; Coulton et al., 2000; Zedlewski and Brauner, 1999). During the 1994-1999 period, participation in the Food Stamp Program declined by 33 percent (U.S. Department of Agriculture, 1999) — a decline only partly accounted for by the improved economy. As a consequence, there is some concern that poor families leaving welfare could be exposed to unprecedented food hardships.

---

[2] A family's income-to-need ratio is their total cash income from all sources, divided by the family's official poverty threshold, as established by the U.S. Bureau of the Census, in the relevant year.

[3] Edin and Lein (1997), in an in-depth study of low-income women in four cities, found that wage-reliant women had an average of 1.6 material hardships (out of six possible hardship problems), compared with an average of 1.1 for welfare-reliant women. However, at least part of this average difference is attributable to the fact that women in the study who were working were more likely to be uninsured — one of the indicators Edin and Lein used in their material hardship scale. In this report, health insurance is discussed in the context of health care access (Chapter 6) rather than in this chapter.

Food insecurity is now widely considered a core indicator of food hardship. A landmark report by the Life Sciences Research Office (Federation of American Societies for Experimental Biology) provided consensus definitions of food insecurity: "Food insecurity exists whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain" (Anderson, 1990, p. 1560).

Despite the growth of the U.S. economy in the mid to late 1990s — and despite the declines in food stamp participation, which could be viewed as indicating lowered need for food assistance — there has been virtually no change in the prevalence of food insecurity and hunger in this country. In 1998, as in 1995, just over 10 percent of all U.S. households were food insecure (Bickel, Carlson, and Nord, 1999). Thus, some 10.5 million households were food insecure in 1998, and over 14 million children lived in such households. Moreover, in 3.7 million households, the level of insecurity was sufficiently great that hunger occurred (Bickel et al., 1999). Thus, even with a strong economy and the existence of a nutritional safety net, many American families are struggling to meet basic food needs.

While not all poor people in the United States are food insecure, and while some people above the poverty level experience hunger, there is a clear and consistent relationship between income and food security/hunger. In the 1998 Current Population Survey, for example, 36.4 percent of households with income below the poverty level, compared with 14.3 percent of households above poverty, were food insecure (Bickel et al., 1999).

The deprivation of a basic need such as food is, of course, undesirable in its own right, but it is also associated with nutritional, health, and developmental problems that make it an important focus for public policy concern. For example, food insufficiency or insecurity has been found to be associated with nutrient intake deficiencies (Kendall, Olson, and Frongillo, 1995,

---

[4] Various provisions of PRWORA reduce benefits for participating families. For example, (1) families now receive food stamps worth a maximum of 100 percent of the U.S. Department of Agriculture's Thrifty Food Plan, down from the previous maximum of 103 percent; (2) the standard deduction used in calculating household benefit levels is capped at 1996 levels; (3) the earnings of students older than age 17 (previously age 22) are now counted toward household income; and (4) energy assistance is now counted as income.

1996; Rose, 1999; Rose and Oliveira, 1997; Tarasuk and Beaton, 1999b); obesity and eating disorders (Olson, 1999; Kendall, Olson, and Frongillo, 1996); and fatigue, illness, and depression in adults (Hamelin, Habicht, and Beaudry, 1999). Moreover, there is increasing evidence that food hardship is related to a variety of problems in children, including higher incidence of illness (otitis media, colds, headaches), increased school absences, concentration deficits, impaired cognitive functioning, and behavior problems (Hamelin et al., 1999; Murphy et al., 1998; Scott and Wehler, 1998; and Wehler et al., 1995).

In sum, food security is an indicator of wellness and, thus, an important health monitoring gauge. The next two sections look at various indicators of nutritional well-being in the Urban Change sample.

A. Food Expenditures and Food Resources

Food Expenditures and Resources: Highlights of the Findings

- Nearly one-third of the women's monthly income was spent on food (an average of $80 per person).
- Working welfare leavers spent about 20 percent of their income on food, compared with 36 percent among recipients who did not work.
- Two-thirds of the sample received food stamps in the prior month; some 5 percent had used emergency food services such as food pantries or soup kitchens.
- Nearly all welfare recipients had food stamp benefits, but under one-third of the women in the work-only group received food stamps — despite the fact that many others appeared eligible.

As shown in Table 3.1, families in the Urban Change survey sample spent an average of just under $80 per person for food in the month prior to the interview, which is about 10 percent lower than households nationally in 1998 ($89 per person) but only slightly lower than the average in households in which the reference person did not have a high school diploma ($81 per person) (U.S. Department of Labor, 1999). In the Urban Change survey sample, there were significant — though relatively modest — group differences in per capita food expenditures among women with different income sources in the prior month, even after adjusting for group differences in household composition and other characteristics.[5] Women who neither were working

---

[5] The data presented in tables throughout this report are not statistically adjusted. However, a footnote in each table indicates which group differences remained statistically significant when background characteristics were controlled. See also Appendix E.

The Project on Devolution and Urban Change

Table 3.1

Food Expenses and Resources, by Work and Welfare Status[a]

Outcome, Prior Month	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Average per capita food expense, immediate family[b] ($)	79.7 **	82.9	80.6	77.8	76.4
Average percentage of total monthly income spent on food[c]	28.2 ***	19.4	25.8	35.4	30.8
Received food stamps (%)	69.1 ***	32.0	93.0	96.6	48.8
Received food through WIC[d] (%)	24.3 ***	14.3	27.3	32.7	20.3
Received emergency food (%)	5.2 ***	2.7	4.6	6.7	8.2
Sample size	3,763	1,240	626	1,468	429

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Per capita food expenses are total grocery expenses for food items, divided by the number of immediate family members. Family members living in the household who shared expenses and resources with the respondent were considered immediate family.

[c] Total income of the immediate family includes food stamp benefits but does not include Earned Income Tax Credits (EITCs).

[d] A respondent was considered to be participating in the Special Supplemental Food Program for Women, Infants, and Children (WIC) if she or any other family member received food through the WIC program in the month prior to the interview.

nor receiving welfare had the lowest per capita food expenditures, and women who had left welfare and were working had the highest.[6]

In poor families, food expenditures represent a critical component of a monthly budget. For the Urban Change sample as a whole, an average of nearly one-third (28.2 percent) of the household's total gross income (which comprised income from all sources, including food stamps) in the prior month was spent on food.[7] Group differences on this indicator of well-being were substantial. Among the women who worked and no longer received welfare, about 20 percent of their total monthly budget was allocated to grocery food items, compared with 35.4 percent among current welfare recipients who did not work. The percentage was nearly as high among women who neither worked nor received welfare (30.8 percent), which is noteworthy, given that these women spent less money per person than women in any other group. Thus, although food expenses were a disproportionately large burden on their budgets, these nonworking former recipients bought less food than other women.

Virtually everyone in the Urban Change survey sample had been receiving food stamps in May 1995, the date used to draw the research sample from administrative records. Table 3.1 shows that, at the time of the 1998-1999 interview, over two-thirds of the sample members were still receiving food stamps. The vast majority of welfare recipients, whether they worked or not, received food stamps in the prior month. Just under one-third of the welfare leavers who worked, and about one-half who were neither employed nor on welfare, were participating in the Food Stamp Program.[8]

The Food Stamp Program has complex eligibility requirements that include tests of assets and income (gross income cannot exceed 130 percent of the poverty level). Unfortunately, the asset data in the Urban Change survey were not sufficiently complete to permit a definitive determination of the percentage of women who, among those *not* receiving food stamps, were eligible to receive them. (This is also true in the paper by Zedlewski and Brauner, 1999, which looked at the link between leaving welfare and the Food Stamp Program.) However, using self-reported income information alone, the data suggest that many food stamp nonrecipients were likely eligible for them. Based on income in the month prior to the interview, 48.2 percent of the working welfare leavers who were *not* receiving food stamps appeared income-eligible for food stamp benefits (not shown in tables). Among nonworking welfare leavers who did not receive food stamps in the prior month, 84.8 percent appeared income-eligible (not shown in tables).[9]

---

[6] Of course, a higher food expenditure does not necessarily result in *more* food; it also could indicate different-quality food or different types of food.

[7] By comparison, national data from the Consumer Expenditure Survey (CEX) for 1998 indicate that U.S. households spent an average of only 8.1 percent of their before-tax income on food. Households in which the reference person was not a high school graduate spent 12.2 percent (U.S. Department of Labor, 1999).

[8] Among the families who received food stamps, the average amount of the benefit in the prior month was $247.52, which represented 29.0 percent of their total income. In the four work/welfare groups, the average monthly benefit among food stamp recipients ranged from a low of $188.54 for women in the work-only group (19.3 percent of their total income) to a high of $272.67 for those in the welfare-only group (33.8 percent of their total income).

[9] About half the women who had left welfare (50.8 percent) did own a vehicle, however, the value of which might have made many ineligible for food stamps. Furthermore, other women may have been ineligible for food stamps based on their citizenship status; some 10.8 percent of welfare leavers were not U.S. citizens.

Another federal food program is the Special Supplemental Food Program for Women, Infants, and Children (WIC). WIC was implemented in 1972 in response to concern about malnutrition among low-income pregnant women and children. About one-fourth of the Urban Change survey sample received WIC benefits in the prior month. WIC participation varied significantly in the four work/welfare groups (even after controlling for background characteristics, including the presence of an age-eligible child), but not as sharply as in the case of food stamps. Welfare recipients who did not work were especially likely to be in the WIC program (32.7 percent), and former recipients who worked were least likely (14.3 percent).[10]

Women in the survey were also asked whether they had used any emergency food services — such as food pantries and soup kitchens — in the month prior to the interview; 5.2 percent of the respondents reported having done so. Women who neither worked nor received welfare were more than three times as likely to have received emergency food in the previous month as were employed welfare leavers (8.2 percent versus 2.5 percent).

Data from the ethnographic sample indicate that food stamps, the WIC program, and food pantries were critical to household resource management in these families, all of whom were food stamp recipients. Food stamps did not ensure that all these families could avoid food hardships, but many women made comments suggesting that food stamps played a major role in helping them avoid severe deprivation:

> *If it wasn't for food stamps, we'd probably starve to death.* Danielle, Philadelphia

> *That food stamps, like I'm glad I have them. They help out a lot, they fill my refrigerator.* Heather, Cleveland

> *I basically look forward to my food stamps, you know, every month. . . . That'd be the only thing I'd really miss.* Glenda, Cleveland

Several women whose food stamps had been terminated or reduced also noted the importance of food stamps:

> *I got cut off once. . . . I was cut off for 6 months. That was the worst. I didn't have no food stamps. I mean I had food still, but you know, God. . . .* Katie, Cleveland

> *I bought like a little, not very much though, really, this month. I mean I used to, we used to get like almost $400 before in food stamps, but it's like a big cut. . . . We don't eat like we used to.* Maria, Cleveland

> *What happens now, it's happened to me. You go to work, you start getting in the 40 hours a week or whatnot, they cut you off quicker than. . . . They don't tell you nothing. . . . You call your caseworker, "Why didn't I get the food stamps this month?" and she goes, "You're working, you're not getting them anymore, you're not eligible."* Wendy, Cleveland

---

[10] Among women who either were pregnant or had an age-eligible child, the percentages who did *not* receive WIC in the prior month are as follows: work-only group, 64.3 percent; work-and-welfare group, 50.0 percent; welfare-only group, 39.1 percent; and no-work, no-welfare group, 49.6 percent.

100

As the last excerpt indicates, there was some evidence of misunderstanding about food stamp rules. Some women believed — or may have been told — either that food stamps and welfare would both be terminated when a recipient found full-time employment or that food stamps would end after a transitional period:

> *You can only receive medical and food stamps for one year while you are working, and after that you are off.* Eileen, Phialdephia

> [Respondent:] *You work now, they just cut you straight off, no check, no stamps, I think it's for two months. Just try it out. You'll never get a check again, but there's a possibility you might get a little bit of food stamps. That's my understanding.*
> [Interviewer:] *So as soon as you get a job on your own . . .*
> [Respondent:] *You're cut off.*
> [Interviewer:] *And food stamps for your kids are gone too?*
> [Respondent:] *Yes.* Linda, Cleveland

> *The food stamps, that's a big thing, right there, that most people are going to miss, is the food stamps. . . . But me trying to buy clothes on a [pay] check, you know, work and buy clothes, and then got to buy food? It's going to be hard, you know what I'm saying? . . . So it's going to be kind of messed up with the food stamps.* Ophelia, Cleveland

Comments such as these are consistent with suspicions that some of the decline in Food Stamp Program participation is a result of inadequate understanding of food stamp eligibility rules on the part of former participants (Zedlewski and Brauner, 1999).

B. Food Insecurity and Hunger

Food Insecurity and Hunger: Highlights of the Findings

- About half the families in the survey were food insecure (compared with 10 percent nationally); over 15 percent had experienced some hunger in the previous year.
- Working welfare leavers were least likely to be food insecure; women who neither worked nor received welfare were most likely.
- Women who received food stamps were more food insecure than those who did not, consistent with prior research.
- The ethnographic data indicate that welfare mothers used a wide range of food management strategies to feed their families; the data suggest that the term "food secure" may not appropriately characterize the situations of low-income families.

The Household Food Security Scale (HFSS) is a national benchmark measure of food security that has been administered by the U.S. Bureau of the Census through its Current Population Survey (CPS) each year since 1995 (Carlson, Andrews, and Bickel, 1999). The HFSS is an 18-item self-report scale that classifies respondents into one of four categories: food secure, food insecure without hunger, food insecure with moderate hunger, and food insecure with severe hunger.[11] The HFSS, which has been found to be reliable and valid for population and individual uses (Frongillo, 1999), was administered to survey respondents in the Urban Change study.

As shown in Table 3.2, only half the families in the Urban Change survey sample were food secure. Fully 48.8 percent (compared with 10.2 percent nationally in 1998) were classified as being food insecure; there were 4,593 children living in these families, compared with 4,431 children living in food-secure households. Just over 15 percent of the Urban Change survey sample experienced hunger in the previous year, compared with 3.6 percent nationally (Bickel et al., 1999).

Food insecurity varied significantly in the four work/welfare groups, even after statistically controlling background characteristics. Table 3.2 shows that food security was highest — and hunger lowest — among former recipients who worked. Women who neither worked nor got welfare were most likely to be food insecure. Current recipients' rate of food insecurity fell between these two leaver groups, and welfare recipients who worked were only modestly better off than those who did not. These findings are broadly consistent with other studies that have found food adequacy positively correlated with employment and negatively correlated with welfare receipt, despite the fact that almost all welfare recipients receive food stamps (Alaimo, Briefel, Frongillo, and Olson, 1998; Cutts, Pheley, and Geppert, 1998; Kendall et al., 1995; Johnson et al., 1999).[12]

Generally, the severe-hunger category of the HFSS has, for households with children, been used as a proxy for hunger among children (Hamilton et al., 1997). However, there is some concern that estimates of children's hunger based on the household-level measure might be inadequate. Consequently, researchers have begun to explore the construction of a separate measure of child hunger using the eight items in the HFSS dealing specifically with children (Nord and Bickel, 1999). These researchers have developed a measure with three categories: child hunger, reduced-quality diet to children, and no child hunger or reduced-quality diet.

Applying the child-specific scale to the Urban Change survey sample reveals that children in 25.9 percent of the families with children under 18 experienced reduced-quality diets (Table 3.2), compared with 9.2 percent of households with children nationally. Moreover, 4.9 percent of the children — compared with only 3.8 percent when using the severe-hunger category of the full household scale — experienced hunger. Nationally, based on the child-specific measure, 1.1 percent of households with children had child hunger (Nord and Bickel, 1999). Differences in the four

---

[11] The actual HFSS scale items, together with the percentages of women in the Urban Change survey sample who gave affirmative responses, are shown in Appendix F. Further information about food insecurity in the Urban Change sample is presented in Polit, London, and Martinez (2000), which is available on MDRC's Web site (www.mdrc.org).

[12] Although women who had left welfare and were working were more likely than women in other groups to be food secure, they were also more likely than welfare recipients to be food insecure without having gotten food stamps in the prior month. About one out of four women in the two welfare leaver groups were food insecure and had not gotten food stamps in the prior month.

The Project on Devolution and Urban Change

Table 3.2

Food Security and Child Hunger, by Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Food security scale[b]					
Food secure	51.2 ***	58.2	50.5	47.5	44.6
Food insecure without hunger	33.2 ***	28.4	33.2	36.3	36.1
Food insecure with moderate hunger	11.8	10.4	12.6	12.0	14.2
Food insecure with severe hunger	3.8	3.0	3.7	4.2	5.2
Food insecure with no food stamps, prior month	13.0	26.0	3.6	1.8	27.5
Child hunger[c]					
No child hunger or reduced-quality diet	69.3 ***	73.8	70.1	66.5	64.3
Child with reduced-quality diet	25.9 ***	22.1	24.3	28.3	31.0
Child with hunger	4.9	4.1	5.6	5.2	4.6
Sample size	3,734	1,231	620	1,459	424

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except "No child hunger or reduced-quality diet" (p = .09). The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Respondents were placed in one of the four food security categories based on their scores on the 18-item Household Food Security Scale.

[c] Respondents were placed in one of the three child hunger categories based on their responses to the eight items on the Household Food Security Scale that concern the nutritional status of children under age 18 in the household. Households without children (4.3 percent of the sample) are not included.

work/welfare groups were generally consistent with the results for the overall food security scale. Children in the no-work, no-welfare group were most likely to have had dietary restrictions, while children of working mothers were least likely to have restrictions on the quality of their diets. Children's *hunger*, however, was not related to their mothers' source of income: About 5 percent of the children in *all* groups had experienced hunger in the previous year. It should be noted that children who were classified as having neither hunger nor a reduced-quality diet could nevertheless have been living in households with food insecurity, consistent with evidence that parents tend to shield their children from hunger insofar as possible (Nord and Bickel, 1999).

There is abundant evidence that federal food programs such as Food Stamps and WIC have beneficial effects on the health and nutrition of participating families (for example, Rose, Habicht, and Devaney, 1998; Owen and Owen, 1997; Moss and Carver, 1998). Nevertheless, it has repeatedly been found that food inadequacies are higher among families who receive food stamps (Alaimo et al., 1998; Cutts et al., 1998; Cohen et al., 1999), WIC (Rose and Oliveira, 1997; Kendall et al., 1995), and emergency food services such as groceries through food pantries (Cutts et al., 1998; Starkey, Gray-Donald, and Kuhnlein, 1999; Tarasuk and Beaton, 1999a) than among families who do not. These relationships presumably reflect the fact that poor families who are food insecure are especially likely to use food programs, not that the use of food programs *leads to* food deprivations.

In the present study, the relationship between food insecurity and the use of these food resources was examined; the results are presented in Table 3.3. As in earlier studies, Urban Change families who received food stamps were significantly less food secure (48.0 percent) than families not receiving food stamps (57.8 percent), and they were significantly more likely to experience hunger and to have children with reduced-quality diets. Receipt of WIC, however, was less strongly related to food security, but nevertheless an interesting pattern emerged. Families who were in the WIC program were significantly *less* likely than those who were not to experience severe hunger, and they were more likely to be able to shield their children from food hardships.[13] Women who said they had used an emergency food service such as a food pantry or food bank in the prior month were more than twice as likely as other women to have experienced hunger (9.2 percent versus 3.5 percent, respectively). Thus, even within low-income families, there appears to be a relationship between food insecurity and receipt of food stamps and emergency food services, presumably through self-selection; that is, those experiencing the most severe material hardships are probably most likely to turn to food programs for help.

Data from the ethnographic interviews provide a richer understanding of the nature of food problems among poor urban families. Although ethnographic respondents were not administered the Household Food Security Scale, they were asked a number of questions about food expenditures, food deprivations, and the use of emergency food services. Based on responses to

---

[13] However, the significant differences between WIC recipients and nonrecipients disappeared when the presence of an age-eligible child and maternal background characteristics were controlled.

104

The Project on Devolution and Urban Change

Table 3.3

Food Security, by Receipt of Food Assistance in Prior Month

	Received Food Stamps[a]		Received WIC[b]		Received Emergency Food[c]	
Outcome (%)	Yes	No	Yes	No	Yes	No
Food security scale[d]						
Food secure	48.0	57.8 ***	51.9	51.0	25.6	52.6 ***
Food insecure without hunger	35.7	27.8 ***	34.8	32.7	39.0	32.9
Food insecure with moderate hunger	12.0	11.7	10.6	12.2	26.2	11.0 ***
Food insecure with severe hunger	4.4	2.7 **	2.6	4.2 *	9.2	3.5 ***
Child hunger[e]						
No child hunger or reduced-quality diet	67.5	73.1 ***	72.0	68.4 *	49.4	70.3 ***
Child with reduced-quality diet	27.0	22.8 **	24.0	26.5	40.9	25.1 ***
Child with hunger	5.3	4.1	4.0	5.1	9.8	4.6 **
Sample size	2,548	1,132	913	2,822	195	3,543

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] A respondent was considered to be a food stamp recipient if she or any other family member received any food stamp benefits in the month prior to the interview.

[b] A respondent was considered to be participating in the Special Supplemental Food Program for Women, Infants, and Children (WIC) if she or any other family member received food through the WIC program in the month prior to the interview.

[c] A respondent was considered to have used emergency food services if she or any other family member received emergency food from a church, food pantry, or food bank in the month prior to the interview.

[d] Respondents were placed in one of the four food security categories based on their scores on the 18-item Household Food Security Scale.

[e] Respondents were placed in one of the three child hunger categories based on their responses to the eight items on the Household Food Security Scale that concern the nutritional status of children under age 18 in the household. Households without children (4.3 percent of the sample) are not included.

these questions, the women were categorized into a food-security category.[14] In the ethnographic sample, about half the women were categorized as food insecure. Here are some examples of how food-insecure women described their food situations:

> *It's not to the point where we didn't have nothing at all. I mean, it's gotten to the point where you had to eat this or you go hungry, but not to where we didn't eat at all.* Gayle, Cleveland

> *The other day, we ran out of everything and we had to go to a church and get food. For canned goods and stuff like that.* Hallie, Cleveland

> *We try to make our meals stretch for two days at a time, because otherwise we wouldn't have anything for the next day's meal.* Tina, Philadelphia

> [Interviewer:] *So how often do you think that happens — like when you need food but can't afford to buy it?*
> [Respondent:] *Like a week. Not that often, sometimes in that whole week there's nothing to make or whatever, and we'll have some meat, we'll just fry up the meat or find a way to cook it. We'll use that up for the whole week until my sister gets her check. . . .* Alissa, Los Angeles

Several women acknowledged that they had experienced food shortages accompanied by hunger. These women sometimes resorted to extreme measures to obtain food — measures such as selling their blood and panhandling:

> *I donated plasma, took in cans, uh, we ended up asking my mother-in-law if she could help us in any way, my mother if she could help us in any way, any way we could get help, we were asking. . . . We managed. I mean, it wasn't easy but we managed.* Linda, Cleveland

> *It was hard, especially when you got kids at home saying, "I'm hungry." . . . I started working at the church as a babysitter. I was getting paid $20 a week and a bag of food every Thursday. . . . Then I was taking in house cleaning at nighttime. I was doing very odd jobs that most people would not dare do, I was making deliveries on pizza, in bad neighborhoods where most people wouldn't go. I mean, I literally took my life in my own hands.* Eileen, Philadelphia

> *I got to live day by day for food for my kids. I have to call down to the shelter things to get them to send you food and you hate doing that because it's embarrassing to, but I have to live day by day. I have to do things so my kids can eat.* Celena, Philadelphia

As the last two excerpts suggest, the women were especially concerned about feeding their children. Many of them indicated that they would go to great lengths, including going without food themselves, to protect their children from hunger, a pattern that has been found in many other studies:

---

[14] To ensure intercoder reliability, transcripts were independently coded by two people, who were able to resolve the handful of categorization discrepancies that occurred. Coding for food insecurity was done for the ethnographic samples in Cleveland and Philadelphia but not for those in Miami and Los Angeles.

> *I'll go maybe three days at a time without eating just so the kids can have their three meals a day.* Wendy, Cleveland

> *I don't worry about me, just for my kids because I can go a day without eating, but as long as my kids [eat].* Celena, Philadelphia

> *I'm the type of person that can go two days without eating. I just focus on my kids, that they eat. I always give them something, even if it's eggs and rice or something.* Amarilis, Miami

Although about half of both the survey and the ethnographic samples were classified as food secure, the ethnographic interviews suggest that the term "food security" might sometimes be misleading in reference to poor families. Most of the mothers in the ethnographic study who were classified as food secure nevertheless expended considerable energy and pieced together numerous strategies to make sure that there was an adequate amount of food for themselves and their children — activities that are plausibly less necessary or extensive among middle-class families who are food secure. Some of these food management strategies are included as items in the HFSS (for example, cutting down on the size of meal portions, changing the composition of meals to incorporate lower-cost foods), and affirmation of these strategies contributes to being classified as food insecure. However, other coping strategies designed to avoid hunger and food deprivation are not covered in the scale.[15]

One strategy that several food-secure women mentioned — a strategy not unique to poor women — was careful and skillful shopping, sometimes involving the purchase of such goods as day-old bread or older meats:

> *I buy on deals. I mean, like um, a lot of people when they go to the grocery store, they see those manager's specials, they won't buy those. But, it's a good thing to buy because legally the meat market cannot sell them if they're bad meats. I mean, I've bought packages of steaks, where I've only spent $2 for 6 steaks.* Melissa, Cleveland

> *I shop at all different markets on food stamp day. I go to Pathmark and get the specials, I'll go to Save-a-Lot. I'll go to all the stores. . . . I clip coupons from the paper and stuff.* Kathy, Philadelphia

---

[15] In the 1995 Current Population Survey Food Security Supplement, 30 potential items for a food security measure were administered, and these items included numerous coping strategies. The coping mechanisms appear to fall into two categories: "internal" strategies, such as cutting the size of a meal, and "external" strategies that involve going outside the household to enlarge the food supply, such as using a food bank. The five "external" strategy items failed to meet statistical criteria for inclusion in the food security scale, although several of the "internal" coping mechanisms *are* included. It has been speculated that this is because internal strategies directly contribute to the severity of the food deprivation experience (for example, smaller portions), while external strategies are designed to *reduce* the severity (G. Bickel, U.S. Department of Agriculture, personal communication, November 23, 1999).

Mothers, including ones who were food secure, often had to rely routinely on supportive friends or relatives for meals or for loans that enabled them to feed their families:

> *Their [R's children's] aunt, her husband had went and closed down this swell house for Cisco, which is the restaurant type, ah, they service restaurants. And she gave me big cans of soup, you know, ah, she gave me this big old box of fish . . . stuff like that. Bags of french fries and stuff, you know, just out of the clear blue. So the Lord is always making a way.* Jannelle, Cleveland

> *I have one sister that comes and brings me groceries. She brings me milk, meats, and potatoes . . . something that she knows she can afford herself. And then sometimes I have friends . . . you know, male friends who will come over and bring a hamburger for my kids.* Rosalie, Los Angeles

> *Well, pretty much my family will help me...when it is time to go to the market or whenever I am lacking like bread, milk, and cereal, and they will pick it up for me or give me a couple of dollars to hold me over to whenever. That is pretty much how I have made it.* Denise, Philadelphia

> *I may borrow from my grandmother or I may go to her house, get stuff out of the freezer, or she'll give me food.* Judy, Miami

Two of the women explicitly mentioned smoking as a strategy to manage food resources:[16]

> *Sometimes smoking is cheaper than eating. You know, a pack of cigarettes will last you all day, better than eating three meals. . . .* Brenda, Cleveland

Current or recent food bank use was mentioned as a strategy by just about half the ethnographic respondents.[17] (The percentage is much higher than food bank use reported in the survey, in part because the survey asked about using a food bank only in the *prior* month.) Some women used food banks at special times, particularly around Thanksgiving or Christmas, but others relied on food banks as a normal part of their strategy to avoid hunger or augment food resources. Food bank use typically occurred at the end of the month, when food stamps ran out:

> *I'm always, every other week — after I lost my job — going up to the food bank, lying about where I'm living so I can get more food from different food banks to feed my daughter.* Brenda, Cleveland

> *You have a lot of, um, I don't know what they call them — food banks through churches during the, well, toward the end of the month, usually the third week in the month. A lot of us have to go to these churches to get food bags.* Janice, Cleveland

---

[16] In the survey sample, hunger (moderate to severe) was modestly, but significantly, associated with smoking: $r = .07$, $p < .01$.

[17] In the two sites where a count was tabulated, 54 percent used a food bank.

> *What they send us in food stamps is not enough for the whole month. It's only enough for 15 days of food. After the 15 days what do we do? . . . [I go to the food bank] once a month. . . . I try and go during the last days of the months when I don't have much anymore.* Angela, Los Angeles

The ethnographic data suggest that while the Household Food Security Scale may be a reliable and valid indicator of hunger for the U.S. population as a whole, it may not adequately describe the food problems that the poorest citizens face. The widespread use of "external" coping strategies among even those families categorized as food secure evinces a daunting struggle that most people who are truly food secure never face. All the women in the ethnographic sample who used food banks were classified as being food insecure, in keeping with the conceptual definition of food security as having access to adequate food "without resorting to emergency food supplies" (Anderson, 1990). But, as shown in Table 3.3, one-fourth of the women in the survey who used a food bank in the prior month were classified on the HFSS as food secure. Furthermore, 35 percent of the survey respondents who were food secure indicated that they had worried that their food would run out before they got money to buy more (not shown). Thus, people can be classified as food secure on the HFSS even though they would *conceptually* be described as food insecure because their "ability to acquire acceptable foods *in socially acceptable ways* is limited *or uncertain" (*Anderson, 1990; emphasis added).

There are also subtle hints in the ethnographic data that these women were extremely proud of their ability to feed their children. They were not always able to pay all their bills, but they made every effort to put food on the table:

> *I'm going to make sure they eat. 'Cause they love to eat!* Ophelia, Cleveland
>
> [Interviewer:] *Is there a time when you needed food but couldn't afford to eat?*
> [Respondent:] *Never. 'Cause I'm going to buy food first.* Sharon, Cleveland
>
> *I keep them clean. I keep them fed. I don't go out there cashing in my food stamps. I'm one of those ones who is trying to do the right thing.* Andrea, Philadelphia

There were also a few references in the ethnographic interviews to mothers' fears that, if their children were not adequately fed, the children would be taken away from them. If there is pride associated with maintaining adequate food — and conversely, shame or fear in not being able to do so — it is possible that the HFSS would lead to underreporting of food insecurity by some.

In summary, the ethnographic data provide rich qualitative descriptions of the food problems of poor urban families and the strategies they use to manage food resources and avoid hunger. There were very few women who did not have to piece together a complex array of tactics to ensure that their families' food needs were satisfied. The use and management of food stamps appeared to be the centerpiece of these tactics.

III. Housing Quality and Housing Insecurity

Poor families experience hardships in relation to their housing as well as in relation to food, and housing also has health implications. As with food insecurity, housing hardships have not abated despite the strength of the U.S. economy. In 1999, as in 1995, 5.3 million American families, who included 4.5 million children — roughly *7.4 percent of all American families* — had "worst-case housing needs." Families have worst-case housing needs if they do not have any rental assistance and pay more than half their income for rent and utilities — or if they live in severely inadequate housing (U.S. Department of Housing and Urban Development, 1999a).[18]

The U.S. government has provided housing subsidies for renters with low incomes ever since the Housing Act of 1937. In 1998, some 1.2 million households lived in public housing, and 2.8 million had Section 8 vouchers or certificates. Section 8 subsidies, which allow people to live in privately owned buildings, are especially valuable as a result of welfare reform because, unlike public housing, the vouchers and certificates can be used to find housing closer to where jobs are located. However, only about one-quarter of the families receiving TANF live in assisted housing (Sard and Daskal, 1998).[19]

Housing problems are linked to health outcomes in a variety of ways. Poor people live in housing that has a higher-than-average number of health and safety hazards, such as inadequate heating, electrical problems, the absence of smoke alarms, lead paint exposure, and infestations by vermin and insects (Edin and Lein, 1997; Kozinet, Endom, Koerner, and Kovar, 1997; Lanphear et al., 1996; Harvey, Sacks, Ryan, and Bender, 1998; Eggleston et al., 1999; Rosenstreich et al., 1997; Docs4Kids Project, 1998). Lead paint poisoning and exposure to cockroach allergens are particular health problems for disadvantaged inner-city children.

Poor people are also more likely to live in crowded homes, and crowding has been linked to higher rates of infectious diseases (Elender, Bentham, and Langford, 1998; Fall et al.,1997) as well as to depression (Sadowski et al., 1999). Crowding has also been associated with a number of health problems among children, including elevated risk for injury, respiratory problems, high blood pressure, and school absences for medical reasons (Anderson, Agran, Winn, and Tran, 1998; Rivara and Barber, 1985; Baker, Taylor, and Henderson, 1998; Evans, Lepore, Shejwal, and Palsane, 1998; Essen, Fogelman, and Head, 1978).

The risks and stresses associated with living in substandard and crowded housing are exacerbated by residence in a neighborhood that is dangerous and crime-ridden. People who live in poor inner-city neighborhoods are more at risk of assaults and injury than those living in less disadvantaged neighborhoods (Kennedy et al., 1998; Grisso et al., 1999; Wallace and Wallace, 1998). They have also been found to be less likely to be proactive in terms of health behaviors and health care, possibly because their dangerous environments discourage them from venturing outside their doors. For example, neighborhood safety problems have been found to be a deterrent to physical activity and to obtaining prenatal care (Morbidity and Mortality Weekly Report, 1999; Nies, Vollman, and Cook, 1999; Yen and Kaplan, 1998; O'Campo, Xue, Wang, and Coughy, 1997; McAllister and Boyle, 1998).[20]

---

[18] Several factors contribute to current housing hardships: The housing stock affordable to low-income families has continued to shrink (a 5 percent drop between 1991 and 1997), rents are rising at twice the rate of general inflation (in 1998, 3.4 percent versus 1.7 percent), and the number of renters at or below 30 percent of median income grew by 3 percent between 1995 and 1997 (U.S. Department of Housing and Urban Development, 1999b). Thus, the gap is growing between the number of low-income families and the number of rental units affordable to them.

[19] Section 8 subsidies are in particularly high demand but are in limited supply. The time that families spend on waiting lists for housing assistance has grown dramatically, at the same time that numbers of applicants have risen in most major cities. For the largest public housing authorities, a family's average time on a waiting list increased from 22 months in 1996 to 33 months in 1998. In some large cities, the wait is substantially longer. For example, the waiting period for Section 8 vouchers is now 5 years in Cleveland and 10 years in Los Angeles (U.S. Department of Housing and Urban Development, 1999b). Between 1995 and 1998, Congress did not authorize funding for new Section 8 vouchers and certificates, but it did provide HUD with 50,000 new vouchers in FY (fiscal year) 1999, specifically targeted to families making the transition from welfare to work (Sard and Daskal, 1998).

Poor families also have less housing security than other families. In the 1997 National Survey of America's Families, 28 percent of the low-income respondents said that they had had problems paying for housing costs in the previous 12 months (Wiseman, 1999). Poor families are especially likely to experience residential turmoil, stemming in part from evictions and in part from interpersonal issues such as marital disruption, domestic violence, and family tensions resulting from "doubling up." High rates of mobility are associated with a number of social and public health problems, including children's poor school performance (Pribesh and Downey, 1999), underutilization of health care (Duchon, Weitzman, and Shinn, 1999), low infant birthweight (Shiono et al., 1997), and homelessness (Shinn et al., 1998; Bassuk et al., 1997). Homelessness and shelter residence have, in turn, been found to be related to various health and mental health problems, including elevated risk of tuberculosis, vulnerability to assault and rape, disturbed sleep patterns, lice and scabies infestation, depression, and posttraumatic stress disorder (Humphreys, Lee, Neylan, and Marmar, 1999; Farmer, 1997; Davis and Kutter, 1998; Zlotnick, 1987; Lanzi, Pascoe, Keltner, and Ramey, 1999; Burt et al., 1999). Children in homeless families have also been found to experience disproportionately a range of physical and, especially, mental health difficulties (Menke and Wagner, 1997; Weinreb, Goldberg, Bassuk, and Perloff, 1998; Cumella, Grattan, and Vostanis, 1998).

In summary, the Urban Change population is one that is vulnerable to housing hardships, which in turn have implications for people's health and well-being. Within this population, housing and employment status are likely to be related in complex ways. On the one hand, employment could have a positive effect on housing outcomes: To the extent that employment results in higher income, it would be expected that working women would live in better and less crowded housing, would reside in safer neighborhoods,[21] and would experience less housing insecurity than nonworking women. On the other hand, many aspects of housing and residence could affect women's entry into the labor force. The most obvious factor is that the poorest inner-city neighborhoods have limited employment opportunities. Residential instability, utility and telephone disconnections, and concerns about safety could all constrain a woman's ability to find and keep a job.

The next three sections summarize health-relevant information about housing quality and hardships, neighborhood quality, and housing insecurity in the Urban Change survey and ethnographic samples.

---

[20] Several researchers have noted that neighborhood poverty is associated with poor health and mental health outcomes, over and above the effect of individual characteristics such as income, education, smoking status, and alcohol consumption (Yen and Kaplan, 1999; Roberts, 1998; Roberts, 1997; Cohen et al., 2000).

[21] South and Crowder (1998), for example, found that employment among single mothers contributed to their ability to move from a poor to a nonpoor neighborhood.

A. Housing Quality and Hardships

Housing Quality and Hardships: Highlights of the Findings

- About one-third of the women in the survey sample had "worst-case housing needs" (that is, paid more than half their income in rent and utilities and did not have housing assistance). Women in the welfare-only group had especially high rates (46.9 percent).
- Some 21 percent of the sample lived in crowded housing (less than one room per person). Crowding was highest among nonworking welfare recipients.
- Over half the women had at least one of seven specified housing problems (for example, with heat, plumbing, or vermin) and more than a quarter had two or more problems. Those in the work-only group were least likely to have such housing problems, and those in the welfare-only group were most likely to have them.

Table 3.4 presents information about housing hardships in the survey sample.[22] Nearly one-third of the women reported that their prior month's housing costs for rent or mortgage plus utilities exceeded 50 percent of their total family income (including food stamps), and these costs were 41.6 percent of their income when food stamps were excluded. Moreover, one out of three women in the sample could be classified as having worst-case housing needs; that is, they paid more than 50 percent of their income (*not* including food stamps) for housing and had no public rental assistance.[23] Women in the welfare-only group were especially likely to have these hardships; nearly half of them (46.9 percent) had worst-case housing needs.

A substantial minority of women in the survey sample (21.3 percent) lived in crowded housing conditions, defined as providing less than one room per person. The most common pattern among those living in crowded housing was for five people to be living in four rooms.

---

[22] In the Urban Change survey sample, few women (9.2 percent) lived in houses they owned; the majority (62.3 percent) lived in other nonsubsidized housing, mostly rented or shared apartments or houses. Some 15.6 percent of the sample lived in a housing project, and another 12.9 percent lived in Section 8 housing. Women in the work-only group were about three times more likely than nonworking welfare recipients to own their homes (14.5 percent versus 4.8 percent, respectively) and were much less likely to be living either in a subsidized housing project or in Section 8 housing (22.0 percent versus 33.6 percent, respectively). On average, women spent $509.80 per month on housing and utility costs, ranging from an average of $278.70 for women living in housing projects to an average of $746.02 for homeowners.

[23] The Urban Change survey data do not allow a determination of whether women were living in "severely inadequate housing" as defined by HUD, which is one of the criteria for determining worst-case needs. However, only about 5 percent of families are classified as having worst-case needs on the basis of this criterion (Kathy Nelson, U.S. Department of Housing and Urban Development, personal communication, January 31, 2000).

The Project on Devolution and Urban Change

Table 3.4

Housing Hardship, by Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Housing expenditures greater than or equal to 50% of total income in prior month[b]					
With food stamps	29.6 ***	21.1	21.8	37.1	38.6
Without food stamps	42.1 ***	23.5	35.2	58.4	47.1
Had worst-case housing needs in prior month[c]	34.1 ***	19.9	29.9	46.9	34.9
Living in a crowded household[d]	21.3 ***	15.1	23.4	26.0	20.4
Housing problems[e]					
1 or more	53.8 ***	46.2	56.9	58.8	53.8
2 or more	25.5 ***	19.9	28.4	28.9	26.2
Gas or electricity turned off 1 or more times in past 12 months	13.5	12.9	13.0	14.5	13.2
Focal child judged to be in unsafe home environment[f]	23.3 ***	16.7	22.7	28.8	18.5
Sample size	3,765	1,240	626	1,468	431

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except "Living in a crowded household." The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Total income of the immediate family includes food stamp benefits but does not include Earned Income Tax Credits (EITCs).

Table 3.4 (continued)

[c] Families have worst-case housing needs if they have no rental assistance and pay more than 50 percent of their income (not including food stamps) for rent and utilities.

[d] Overcrowding is defined as having less than one room per person (not including bathrooms).

[e] Respondents indicated whether they had any of the following housing problems: broken windows, leaky ceilings, roaches/vermin, and problems with wiring, plumbing, heating, and appliances.

[f] Interviewers rated whether they observed potentially dangerous structural or health hazards for a focal child.

Working welfare leavers had the lowest rate of crowding (15.1 percent), and those in the welfare-only group had the highest (26.0 percent).[24]

In the survey, women were asked a series of questions relating to problems with their housing conditions: whether there were broken windows, leaky ceilings or roofs, and roaches or vermin at their residence; and whether they had problems with heating, plumbing, wiring, or major appliances. The most commonly reported problem was infestation by vermin and insects, reported by 40.2 percent of the sample. Overall, more than half the sample (53.8 percent) said they had at least one of the seven housing problems; about a quarter of the sample had two or more housing problems, similar to the rate found in an earlier study of welfare mothers (Edin and Lein, 1997). As shown in Table 3.4, group differences were significant: Women who had left welfare and were working were least likely to have a housing problem (46.2 percent), and they were also least likely to have multiple problems (19.9 percent).Welfare recipients, whether they worked or not, were most likely to have two or more housing problems.

Survey respondents were also asked whether they had had their gas or electricity turned off at any point in the previous 12 months because they could not afford to pay the bill. Nearly 13 percent of the women in the sample said that their utilities had been turned off at least once in the past year. Women in the four work/welfare groups had similar rates of utility cutoff.

At the conclusion of the survey interviews, interviewers made observations about safety factors in the women's homes. Specifically, interviewers indicated whether they thought there were potentially dangerous structural or health hazards for a focal child.[25] Table 3.4 shows that interviewers rated nearly one-quarter of the homes (23.3 percent) as having a safety concern for the children. Observed risks were highest in the welfare-only group (28.8 percent) and lowest in the work-only group (16.7 percent); the group differences were significant.

Many women in the ethnographic sample experienced an array of housing hardships that not only were unpleasant and stressful but also posed health and safety risks. Consistent with the survey findings, infestations were the most common problem, reported by over half the women:

> *I'd like to get out of here. There's rats running around in here. . . . I've seen them out there last winter outside . . . so now, they're inside this building.* Dan, Philadelphia
>
> *That doggone bug! [pointing to one in the room] Yeah, that's another thing I have to do, exterminate. It was, like, bug-infested when I moved in here. . . . I got spiders, roaches, ants, all kinds of stuff around here. The house is old — 71 years old! And it's infested with something.* Jackie, Cleveland

---

[24] After background characteristics were controlled, however, the differences among the four work/welfare groups with regard to crowding were no longer significant, in large part because of group differences in the number of children in the household.

[25] The focal child was a randomly selected child age 2-6 or 12-18, about whom mothers were asked a battery of questions. Information about focal children is presented in Chapter 2 (see Table 2.8) and Chapter 7.

> *Cockroaches, yeah definitely I have cockroaches. Almost to the, oh my God, to the disgusting point. If they'd stay hidden in the walls I could deal with them.* Brenda, Cleveland

> *We're very mice-infected. The whole building is. Matter of fact, they got termites. . . . We got spiders, we got roaches, we got — you name it, we got it.* D. Williams, Los Angeles

Like the survey respondents, many of the ethnographic respondents had multiple housing problems, including the kinds specified in the survey, as well as several others:

> *I am having a real problem with rodents. The reason why I keep my washer and drier and refrigerator in the little thing, my daughter's foot went through the whole floor. . . . The walls, they just slapped paneling on big humongous holes, they just did cosmetic work. . . . It's cold [in here], the vents ain't right. I had a leak in my basement, the water was as high as my ankle in my basement.* Eileen, Philadelphia

> *There are cockroaches. Right now, if it rains heavily, the living room gets wet. That's why I can't have furniture or anything. I have broken windows in the living room and there's some stuff broken in the kitchen. The bathroom has to be fixed. There are things to be done here!* Carmen, Miami

> *I have live wires on the outside of the house, live wires in the basement. Got holes in the house. I've had no bathroom sink since March. I asked the landlord to come out and fix this [pointing] in February — see the mold?* Wendy, Cleveland

> *Sometimes the mice get so bad you have to get those stickers. You know, they was coming in through the front door. . . . The windows, like they need fixing. Rain still coming in. . . . Like this needs fixing, the cabinets. This little light switch thing. The commode is broke. . . . That what they need to be doing, just put a tent over the whole damn building.* Jefferson, Los Angeles

Complaints about landlords' negligence were common. With some exceptions — and in many cases the exceptions were women living in housing owned by friends or relatives — the women struggled to have housing problems rectified by unresponsive landlords:

> *My landlord is a scumbag. My heater has not been working for months.* Kitina, Philadelphia

> *My landlord don't fix nothing, as you can see. We got things mostly rigged in here, like my banister. My light socket, you got to punch the wall for it to come on. . . . He don't want to fix nothing.* Celena, Philadelphia

> *When I moved here I didn't have keys to my back door. They still won't give me, they still haven't gave me keys to my back door. My bathroom was messed up, they wouldn't fix my bathroom. . . . The tile was coming off the tub, the toilet broke, the tile was coming up off of the floor. The bathroom window won't close.*

> *So they wouldn't fix none of that. And I was like, okay, either you fix it or you don't get paid. And they wouldn't fix it.* Blue, Los Angeles

> *I left there because the landlord wasn't doing right. . . . He got high one night and forgot that he left his water running in the bathroom and his apartment was on top of mines and it caused my kitchen cabinet to drop off the wall and broke all my dishes. . . . I had put the floor down myself and it destroyed the floor and broke up all the cabinets, and he told me he was not going to be fully responsible.* Marie, Philadelphia

Several of the women worried about hazardous conditions inside their homes. Here are examples of housing problems that caused concern about the safety and health of the women's children:

> *There was a fume coming up through my heat vent. . . . I thought it was some hazardous toxic waste material, that had been rising up through my basement floor. . . . [The landlord] sent somebody to clean it out, and the man was coughing and kept choking a long time. And he was saying it was good that we found it out when we did, because it was, like, smoking.* Jannelle, Cleveland

> *We had rat problems in the back, out in the alley. And problems with mosquitos 'cause going down the hill, there's a little dip and there's like ditches and water just sits there all the time. My son, four years ago, got bit by a mosquito and he got encephalitis. From the stagnant water down here. That was not sprayed. The lady down the street has meningitis, at the same time my son had the encephalitis. That's why they said it was the mosquitos.* Susan, Cleveland

> *They fixed the kitchen ceiling. They had to come 10 times just to fix it, and they never fixed it. They hired some idiot to do it. The person who did it didn't know what he was doing, because it kept leaking and things fell. The whole roof thing fell. It could have killed somebody.* Alissa, Los Angeles

> *My stove was leaking gas, it had a gas leak. . . . You know I smell gas every time. I'm hoping there's nothing wrong there. I even called the gas company. But you could smell gas and my oven was always hot. . . . Just recently there was a big gas leak. The whole pipe just busted, finally.* Michelle, Los Angeles

Problems with lead paint were among the hazards that concerned several of these mothers, particularly in Cleveland:

> *My 6-year-old, I have to have her tested this month. Her blood level is 14. Up to 15 is normal.*[26] *You know, it's like borderline.* Janice, Cleveland

> *If we stay here for much longer, that [high lead content] could cause mental problems. . . . When we were in Arizona, we had her tested, she was all the way down to*

---

[26] The criterion for elevated blood lead is generally 10 or more micrograms per deciliter (see, for example, Lanphear et al., 1996).

6, which is normal. And we were only here for six weeks and she's up to 15. Brenda, Cleveland

We're trying to move. We have to move because of the lead levels and he [landlord] won't do anything. Brenda, Cleveland

In summary, material hardships involving the housing that these women were able to afford were common and caused considerable distress, discomfort, and concerns about their family's safety and well-being.

B. Neighborhood Quality

Neighborhood Quality: Highlights of the Findings

- About 40 percent of the women rated their neighborhoods unfavorably, and one in four said there was gang violence; welfare recipients — whether or not they worked — were especially likely to consider their neighborhoods undesirable and to report gang violence.
- One out of six women, with similar rates in all four work/welfare groups, said that either they or their children had been robbed, mugged, or attacked in the previous year.
- Interviewers rated nearly two-thirds of the survey sample as having one or more neighborhood problems (for example, vandalism, vacant lots, abandoned buildings). Welfare recipients had higher rates of such problems than welfare leavers.
- The ethnographic data suggest that many women had fears for their personal safety and for the safety of their children — and that such fears often led them to stay secluded in their homes, venturing out only when necessary.

The inner-city neighborhoods from which the Urban Change survey sample was drawn were among the most economically disadvantaged in the four sites — although it is important to note that women were not necessarily still living in the neighborhoods where they had resided in May 1995.[27] Many of the women in the survey sample were aware that their neighborhood was not the best place to live and raise children. Nearly two out of five respondents rated their neighborhood as "fair," "poor," or "awful." (Conversely, however, about 60 percent of the sample described their neighborhoods as "excellent" or "good.") Table 3.5 shows that women who

---

[27] Data from the Neighborhood Indicators component of the Urban Change project permitted a preliminary exploration of mobility patterns in the Urban Change survey sample. Altogether, about half (53.3 percent) the women had moved to different census tracts, and the four work/welfare groups had similar rates of mobility. On average, moves were positive; for example, the average poverty rate of the original (May 1995) census tracts was 38.1 percent, compared with an average poverty rate of 28.6 percent for the tracts where respondents *who had moved* were living when interviewed. Among the movers, improvements were observed for all four groups, but women in the two working groups experienced somewhat larger improvements than women in the two nonworking groups.

The Project on Devolution and Urban Change

Table 3.5

Neighborhood Characteristics, by Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Living in an undesirable neighborhood[b]	39.8 ***	35.0	41.3	44.1	36.6
Gang violence in neighborhood, past 12 months	24.2 ***	18.9	29.9	27.3	20.9
Respondent or her child(ren) robbed, mugged, or attacked, past 12 months	16.8	16.0	16.3	17.8	16.5
Respondent or child witnessed a violent crime in neighborhood, past 12 months	14.2 **	11.6	15.7	16.0	13.4
Neighborhood problems[c]					
1 or more	62.5 ***	55.4	63.9	69.1	58.2
2 or more	46.8 ***	39.9	47.9	53.5	42.2
Sample size	3,765	1,240	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] An "undesirable neighborhood" was one that respondents rated as fair, poor, or awful as a place to live and raise children.

[c] Neighborhood problems are based on the interviewer's observations of five characteristics in the vicinity of the respondent's home: vacant lots, vandalism, abandoned buildings, teenage gangs, and litter or garbage in the streets.

received welfare were more likely than women in either of the two nonwelfare groups to consider their neighborhood undesirable.

About one-quarter of the respondents reported that there had been gang violence in their neighborhood within the previous year. There were significant differences among women in the four work/welfare groups: Women who were receiving welfare (whether they worked or not) were most likely to report gang violence. Among the full survey sample, 14.2 percent said that either they or one of their children had witnessed a violent crime (such as a shooting or stabbing of someone) in their neighborhood in the previous year, and an even higher percentage of women (16.8 percent) said that they or a child had been mugged, robbed, or attacked. All groups had similar experiences with robbery or mugging, but women in the two welfare groups were somewhat more likely to have witnessed a violent crime in their neighborhood.

Interviewers recorded observations about certain neighborhood characteristics — whether, within a block or two of the respondent's home, there were (1) large groups of teenagers hanging out in the street, (2) vacant lots, (3) litter and garbage on the street or sidewalk, (4) abandoned or boarded-up buildings, or (5) vandalism, such as graffiti. Visible neighborhood problems such as these have been shown to be more strongly correlated with certain health problems than standard indicators of socioeconomic status (see, for example, Cohen et al., 2000).[28] Each of these problems was present in the neighborhoods of at least one-third of the sample members, with the most common problem being vacant lots near respondents' homes (43.2 percent). Over 60 percent of the sample had at least one of these problems, and 46.8 percent had two or more. As shown in Table 3.5, welfare recipients who did not work were most likely to live in areas rated by interviewers as having undesirable features. However, the majority of women in all four of the work/welfare groups lived in neighborhoods with at least one of the five problems.

The ethnographic data provide a rich account of the anxieties that many of the women had about the safety of their neighborhoods. By far the most frequently mentioned concern was crime, in general, and drugs, in particular. Women who did not worry about drugs and associated problems were in the minority:

> *There's a lot of drug activity coming into the neighborhood. . . . I couldn't walk to the corner store without somebody asking me if I was all right, if I needed to get hooked up or if I needed a rock or something.* Linda, Cleveland
>
> *The house next door, it has crack heads, two houses up it has crack heads, they wheel and deal dope.* Janice, Cleveland
>
> *You have your little drug dealers everywhere. People are always getting shot over here, always.* Maria, Cleveland

---

[28] The "Broken Windows" theory posits that broken windows are an outward sign of social disorganization and that the physical environment's appearance provides messages that regulate individual behavior, including health-related behavior (Cohen et al., 2000).

> *And they're running up [in her building], they sell drugs. And when they raid the house, the only way into my house is upstairs. The other people have two front doors and two side doors. I'm upstairs. . . . It's hard.* Michelle, Los Angeles

Most women in the ethnographic sample did not mention gangs per se as a problem, except in Los Angeles, where the majority of respondents discussed gang-related problems. However, in all four sites, robberies, break-ins, and violent crimes and shootings were a constant source of worry and fear:

> *Somebody just got shot on 59th and Herman. A young teenage boy got shot and killed. Uh, up on Madison and West Boulevard a police officer was killed yesterday. They killed the person who did it. I mean, there's a lot of violence and everything.* Linda, Cleveland

> *We were like hostages in our own homes, because if you go out in the street you might get shot. In fact, one of our guys, one of my son's playmates, his mother got shot on a drive-by.* Rochelle, Cleveland

> *They be shooting around here, they be fighting. Oh, it's hard. It's okay, but I keep my eyes in the back of [my head].* E. Williams, Los Angeles

> *I've been here for a while, and I guess in about the last six months, 10 or 12 persons have got killed over here. I'm serious, one right here on this corner right across the street, one on this corner, and a Mexican guy got shot here downstairs, and on the same day this little 17-year-old boy got killed across the street from me. I just looked out the door and seen a boy laying on the ground and called 911. And uh, a few minutes later, we heard another, a lot of gunshots about a block and a half from here.* Fatimah, Los Angeles

Fears about their personal safety kept some women secluded in their homes — off the streets and even off front porches and sidewalks. This was especially true at night; but even during the day, some women worried that venturing out — even to a local grocery store — was risky:

> *It's drug-infested. We literally used to hide in the house, me and my daughter. I would like, go to the grocery store, pay the bill, back in the house.* Jackie, Cleveland

> *I'm fearful to live here because, we're fearful for our personal safety. Sometimes I'm fearful that, because there may be some other people having a fight and it has nothing to do with me, but we could get hurt. If we're sitting around out there, we might get hurt.* Kathy, Cleveland

> *I'm scared to work around here. . . . People walking around the street I don't like. I ain't trying to have no money in my pocket, so none of these people around here [have something] to snatch.* Blue, Los Angeles

> *[I wouldn't take an early job] because if it was, like, very early, I wouldn't take it because it's very risky being out on the street alone, waiting for the buses, and they don't come quickly or something.* Delia, Los Angeles

The risks that these women faced personally were twofold: the possibility of being injured, killed, mugged, robbed, or harassed while outside their home, on the one hand; and the possibility that during their absence from home their residence would be burglarized or vandalized. One woman in Philadelphia, for example, had been about to go to the laundromat but noticed a large group of teenagers congregating outside her house. She was afraid to leave, because she thought they would hassle her, and she also feared that they would "torch" or destroy her house if they knew it was empty. Another woman said:

> *My house has been broken into before. . . . They watch me, because ain't nobody going to rob you in the day, knowing you don't work — unless they seen you leave, know where you're going, and know when you are coming back.* Marie, Philadelphia

Such fears clearly made it difficult for the women to feel comfortable taking jobs that would force them to walk through their dangerous neighborhoods (and leave their houses empty) to get to work, particularly if the commute involved walking to or from their homes in the dark. Furthermore, employment sometimes resulted in worries about their children's exposure to dangers. One working mother in Miami, who relied on her older son to take her toddler to daycare, explained:

> *I must work because I need the money, but I would rather not work. The difficult thing for me is that the oldest boy has to take him [the toddler] to daycare and pick him up. He's 14 and it's dangerous to walk back and forth.* Amarilis, Miami

As this example indicates, these mothers had grave concerns about the welfare and safety of their children. They worried about the possibility that their children would be physically injured (for example, through an accidental shooting or by drunk or drug-using drivers), but they also grappled with the conviction that their children should not be exposed to drug activity, prostitution, gang wars, vandalism, and other street crime. Many women (especially the mothers of boys) feared not only that such exposure could scar or jade their children but also that it might lead them into a life of crime:

> *You got to worry about it, you have to deal with things like the drugs and the gangs. And you got to worry about your children getting into it themselves. It's like a daily struggle.* Olivia, Cleveland

> *I don't worry about me in particular, because I can handle myself. But the kids, I worry about them, you know, them getting affiliated with the little gangs and the drugs, and being persuaded into doing bad and stupid things.* Wendy, Cleveland

> *I don't even let my 8-year-old out. My kids ain't allowed out. 'Cause if they learn that, they'll be in jail with them.* Danielle, Philadelphia

As noted earlier, residential instability has been found to be associated with negative outcomes, such as homelessness. However, the ethnographic data indicate that, for many of these women — who were living in environments that they themselves described as "like a ghetto" — residential mobility represented an important goal. A number of women indicated a strong desire to move out of the neighborhood and, often, out of the city entirely. Some sorrowfully acknowledged that their income would likely never permit them to move to a better neighborhood.

Consistent with the survey findings, not all women in the ethnographic sample had complaints about their neighborhood. Some women voiced strong praise of their neighbors and their neighborhood, saying that they felt safe, that their neighbors were friendly, and that crime was not a major issue.[29] These respondents often lived in cohesive, socially integrated neighborhoods where people cared about how their houses looked, how the children behaved, and what kinds of activities transpired there; consequently, they cooperated with each other:

> *The parents around here, if one kid does something and the other parent will go and tell the parent. . . . We do try to keep each other informed and most of the parents actually watch the kids and watch out over other kids.* Olivia, Cleveland

> *One kid got hit last year and we just immediately dialed 911 and then someone ran and told the mom. . . . Then it was a lady got attacked, her and her boyfriend were fighting right out here. . . .He chased, she must have jumped out of the car, and he parked the car and started beating her again. And somebody was passing and stopped and came and held him down 'til the police came. So I think this is a very cooperating area.* Tasha, Cleveland

> *Most of the people on this block are homeowners and they have block meetings all the time and they look out for each other, they watch the houses, they watch the kids.* Lisa, Philadelphia

However, it was not only women who lived in relatively quiet, friendly areas who were uncritical of their neighborhoods. Some women who lived in neighborhoods characterized by violence and crime nevertheless thought their neighborhoods were tolerable. This sometimes happened because the women had previously lived in even worse areas. In other cases, however, the women appeared to have grown immune to the chaos of their surroundings, saying that they were "used to it." And some were able to rationalize the situation, indicating their belief that many of the problems they experienced were almost universal. For example, one woman in Cleveland indicated that there were drugs and violence nearby, that her kids could not go outside to play, and that it wasn't wise to be outside after dark. She then described her area as a "typical neighborhood, I guess; as typical as anywhere." The notion that drugs and crime were everywhere and could not be avoided was expressed by several women:

> *Every neighborhood's practically, mostly the same, you know. Everywhere you go there's going to be drugs and gangs, you know.* Katie, Cleveland

---

[29] All the ethnographic respondents were drawn from three neighborhoods per site. There is considerable heterogeneity in the women's descriptions *of the same general neighborhood*. The data suggest that women defined "neighborhood" considerably more narrowly than the researchers did. When the women talked about their neighborhood, they usually appeared to be talking about their own street or even only their block, rather than a census tract.

> *It's not a real bad neighborhood, no badder than any other neighborhood. It's occasional drugs in the neighborhood, up on the corner.* Gloria, Cleveland

> *Okay, all the neighborhoods now is kind of rough. It's not the neighbors, it's not the people who stay in the neighborhood. It's the people who come to the neighborhood.* D. Williams, Los Angeles

Thus, the ethnographic data suggest that the survey respondents' ratings of the desirability of their neighborhood as a place to live and raise children may have been skewed by their prior experience with worse neighborhoods *and* their inexperience with much better ones. This interpretation is consistent with the fact that over half the women in the survey sample (51.8 percent) who rated their neighborhood as a "good" or "excellent" place to live nevertheless had at least one interviewer-observed neighborhood problem, such as vandalism, abandoned buildings, and so on.

C. Housing Insecurity

Housing Insecurity: Highlights of the Findings

- Some 2.5 percent of the women had been homeless or lived in an emergency shelter in the previous 12 months; nonworking welfare recipients were especially likely to have been homeless or sheltered.
- More than one out of four women said they had had trouble finding a good place to live in the past year; again, this was especially true among women in the welfare-only group.
- One out of ten women had moved at least twice in the past year, and one out of ten also said she had had to "double up" with another household in that period.
- Across all indicators of housing insecurity, women in the work-only group had the most favorable outcomes, and those in the welfare-only group had the worst outcomes.
- In the ethnographic interviews, a substantial minority of women reported episodes of homelessness and shelter residence, and they described persistent housing problems that required them to piece together strategies that led them from one unsuitable arrangement to another.

As shown in Table 3.6, 2.5 percent of the women in the Urban Change survey sample said that they had been homeless or lived in emergency shelter at some point in the 12 months prior to the 1998-1999 interview.[30] A disproportionately large number of women with a recent history of homelessness had no children living with them, but over 200 children under age 18

---

[30] At the time of the interview, 21 women (0.5 percent) were actually homeless or living in a shelter. Given the difficulty of locating such women, it is quite probable that women experiencing homelessness and residential turmoil are underrepresented in the sample.

124

The Project on Devolution and Urban Change

Table 3.6

Housing Insecurity, by Work and Welfare Status[a]

Outcome, Past 12 Months (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Homeless or lived in an emergency shelter	2.5 **	1.3	2.1	3.6	2.8
Evicted	3.4 **	2.0	4.5	4.4	2.3
Had trouble finding a good place to live	28.1 ***	23.2	28.3	32.0	29.0
Moved 2 or more times	9.9 **	7.7	11.2	11.3	9.8
Had to move in with another household	9.7	8.2	9.9	10.7	10.2
Sample size	3,762	1,239	626	1,467	430

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

lived with mothers who reported homelessness or shelter use in the past year (not shown in tables). Working welfare leavers were least likely to have experienced housing insecurity, while welfare recipients without employment were most likely to have been homeless or sheltered.

Among women in the survey sample, 3.4 percent reported that they had been evicted from their residence in the previous year. Of those evicted, 30 percent had had an episode of homelessness or shelter residence in the prior year (not shown). Welfare recipients — whether they worked or not — were about twice as likely as welfare leavers to have been evicted in the previous year.

More than one out of four women in the survey sample (28.1 percent) reported that they had had trouble finding a good place to live in the prior year. Although women in the work-only group were least likely to report housing difficulties, it is noteworthy that nearly one out of four of them said they had had trouble finding adequate housing.

Residential instability was relatively common in the survey sample, with just over 30 percent having moved at least once in the previous year (not shown) and about 10 percent having moved two times or more. Compared with women in the other three groups, women in the work-only group were least likely to have moved twice or more (7.7 percent). Another type of residential turbulence concerns having to move in with another household; such "doubling up" was experienced in the previous year by just 9.7 percent of the women in the survey sample. Group differences were not statistically significant.

In the ethnographic interviews, many women spoke about housing instability and difficulties finding adequate housing. Unlike the survey data, the ethnographic data are able to reveal the dynamic aspects of housing problems, such as the sequencing of events that created housing insecurity, and the experiences that subsequently ensued.

Like the women with food security problems, women with persistent housing problems tended to piece together strategies — sequentially rather than simultaneously — to find shelter. Women with ongoing housing difficulties tended to move from one unsuitable arrangement to another in search of acceptable and affordable homes for themselves and their children. A pattern that emerged among several women was the loss of housing (for example, because of an eviction, a fire, or the sale of a property), followed by doubling up with relatives in crowded and tumultuous circumstances, followed by, in some cases, shelter dwelling and, finally, by another housing arrangement — typically one with various deficiencies and problems. For example, one woman in Philadelphia moved back in with her mother when her welfare check was withheld for failure to return a form:

> *So I was staying at my mom's, but it's always [hard] living with my mom. She's got a drunken son, he wrecks the house all the time. He gets drunk and smashes everything. And I didn't want my kids to grow up like that. So I moved out and I never went back.* Danielle, Philadelphia

This woman then moved out of her mother's house into a rat-infested building where she and her children were living in one room. The building, however, was about to be sold; she believed that she would need to go into a shelter if her cousin wouldn't take her in, and she worried that she would not be able to get into a shelter.

Another woman's housing odyssey began with a move that led to a major problem:

> *I had just moved in an apartment, and the boiler blew up. That apartment in East Cleveland. All my stuff got burned up, I had nothing. And I went into this shelter.* Sharon, Cleveland

She stayed in the shelter for two months, until she found the apartment where she was living at the time of the interview — an apartment that had broken windows, exposed electrical wires, dozens of mice and rats, and a nonworking refrigerator, stove, and bathtub.

A number of the women in the ethnographic sample were disheartened by the unpleasant circumstances they had to endure when they were forced to double up with another household. As the woman in Philadelphia who had moved in with her mother explained:

> *I started putting money aside so I could get out of there because she only had a two-bedroom place and she still had my two younger brothers living with her, and then she had me and my three children and we had to, like, stay in her front living room on the floor or sleep in her room with her.* Tina, Philadelphia

Some of the women's housing security problems led them to live with an abusive partners, as exemplified by a woman from Philadelphia:

> *Like, we been through more things than you could ever imagine. My mom's home got burned out and it, like, threw us off guard 'cause we didn't have nowhere to go. There wasn't no agencies that would help us. We wound up living in a car. . . . [Then] we lived in one room with a potbelly stove. I had to go out at night time with a little wagon to get wood. We didn't have no gas. . . . Well, I found out that glass bottles can burn. Teddy bears burn great. . . . [Then] I was in a shelter with my kids. It lasted, like, two months and that's when I asked their father, could I move in with him. . . . So when we moved in with him, like, the only thing I didn't applause about was that they were doing a lot of drugs in our house. I would have to keep my kids in one room. My kids would come downstairs to sit on the furniture — we were finding needles or drug bags or crack vials. Like, I got to the point where, you know, I just got tired of the beatings, the abuse, the words.* Eileen, Philadelhphia

A substantial minority of women in the ethnographic sample (over one-third in Cleveland, for example) had been homeless or lived in a shelter at some point in their lives — some because of their own drug use, but most because of circumstances such as those just described. Here is how one woman from Los Angeles described her previous experiences with homelessness:

> *[When I was 15], I would always be thrown out by my mom. . . . I was seven months pregnant and my mom threw me out, she got into a big fight with her boyfriend, she threw me out. And I've been in the streets since. My brother came with me. . . . We were on the streets. I lived on the streets basically all my life. Even my mom, we were homeless with my mom, we lived in garages.* Michelle, Los Angeles

Several of the women explicitly mentioned concerns about future homelessness, for themselves or for other women:

I think if they're not on welfare and they're not working, if they have a child, then either they're living off someone, living off someone else. They're probably moving from place to place. They probably don't have nowhere to go. Jonetta, Cleveland

I mean, if I went, you know, and I did everything by the [welfare agency's] rule, I don't think I'd have a place right now. I think I'd be, like, living under a bridge or something. Heather, Cleveland

[Interviewer:] *What about mothers who move off welfare and do not go to work, do you know what's happening to them? Do you see them at the community center?*
[Respondent:] *I see them coming in every day. And they're growing in number. . . . Some of them are becoming homeless.*
[Interviewer:] *What do you think that you would have to do if you couldn't get welfare or a job?*
[Respondent:] *I'd probably end up on the street.* Linda, Cleveland

In summary, although most of the women in the ethnographic sample were living in fairly stable housing at the time of the interview, many had been living and were continuing to live in precarious financial situations that placed them at risk of disruptive living situations, and many expressed concerns about what might happen to their housing as a result of welfare reform.

IV. Overall Material Hardship

Material Hardships: Highlights of the Findings

- On a summary scale that included eight indicators of material hardship measured in the survey, 83 percent of the sample had at least one.
- Women in the welfare-only group had the highest number of material hardships, and those in the work-only group had the fewest. Even so, about 75 percent of the latter group experienced material hardships of one type or another.

Material hardship scales, pioneered by Mayer and Jencks (1989), capture hardships across domains, such as food sufficiency, housing adequacy, and so on.[31] Some people may experience primarily one kind of hardship because of resource allocation decisions, but others may endure multiple and diverse hardships.

---

[31] Material hardship scales often include indicators of health care access and health insurance, topics that are covered in Chapter 6 of this report.

Researchers have included various indicators in material hardship scales; typically, there are six to eight indicators (Mayer and Jencks, 1989; Edin and Lein, 1997; Coulton et al., 2000). In the present study, a scale was constructed with eight material hardships[32] discussed in this chapter: food insecurity, emergency food use, homelessness or shelter residence, paying more than 50 percent of total income on housing, utility shutoffs, two or more housing problems, witnessing a violent crime in the neighborhood, and two or more interviewer-observed neighborhood problems.

For the sample as a whole, the total number of hardships ranged from 0 to 7, and the average number was 1.8. (See Table 3.7.) Only 17.1 percent of the sample had none of the eight material hardships, and (28.1 percent) had three or more. As shown in the table, working welfare leavers had fewer hardships than other women. Nonworking welfare recipients had the highest average number of hardships, and more than one-third had three or more. These group differences persisted even when the women's background characteristics were controlled. However, even among the group with the fewest hardships — working women who had left welfare — three out of four had at least one material hardship, and about one-fifth had three or more.

V. Discussion

Nutritional status, housing status, and personal safety are important indicators of wellness. Deprivations of basic needs for food and shelter are intrinsically troubling, but they are also of public concern because of their link to numerous health and developmental problems, the burden for which is shared by the entire society.

Despite the current strength of the U.S. economy, millions of American families experience food and housing hardships, suggesting that a strong economy is not in itself sufficient to ensure universal access to basic necessities. Not surprisingly, material hardships are more acute in the Urban Change population than in a general population. For example, for the Urban Change survey sample as a whole, fully half the families were food insecure. This is substantially higher than the 10.2 percent rate found nationally and higher also than the 38.8 percent rate among households with incomes below 50 percent of the poverty level in 1998 (Bickel et al., 1999). Thus, even though about half the sample were working, the Urban Change population was an even more disadvantaged group than people living in poverty nationally.

Women in the Urban Change survey sample who had left welfare and obtained paid jobs were better off in terms of virtually all indicators of material hardship than those who continued to rely on welfare — which is consistent with the fact that their incomes were higher. Welfare recipients who had no paid employment, by contrast, had high rates of food and housing hardships. Welfare leavers who were not working generally had material hardships equal to, or in some cases

---

[32] The method used to select indicators for the scale in the present study was similar to that used by Mayer and Jencks (1989) and Edin and Lein (1997). That is, the indicators are ones that correlate significantly with a question that asked respondents to indicate their level of satisfaction with their current standard of living. In this study, the indicator most strongly correlated is food insecurity ($r = .31$). Overall, only 29.4 percent of the women said they were dissatisfied with their current standard of living; dissatisfaction was lowest in the work-only group (22.7 percent) and highest in the welfare-only group (35.6 percent).

The Project on Devolution and Urban Change

Table 3.7

Overall Material Hardship,[a] by Work and Welfare Status[b]

Outcome	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Material hardships[a] (%)						
Mean	1.8	***	1.5	1.8	2.1	1.9
None	17.1	***	25.3	16.5	11.1	14.4
1-2	54.8		55.4	57.2	53.3	55.0
3 or more	28.1	***	19.3	26.4	35.6	30.6
Sample size	3,765		1,240	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[b] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

130

greater than, women who were welfare recipients. These group differences in material hardship cannot be accounted for by the fact that the groups were different in terms of ethnicity, educational attainment, living arrangements, or household composition. Almost all the group differences remained significant even when these and other characteristics were controlled.

Although material hardships were significantly different for women in the four work/welfare groups in the Urban Change survey sample, it is noteworthy that *the differences were generally not substantial*. For example, nearly half the working welfare leavers were food insecure, 15 percent of them had experienced hunger, and 75 percent of them had at least one material hardship. Thus, even if welfare reform succeeds in moving welfare recipients off of welfare and into paid employment, sizable numbers of them are likely to continue having problems acquiring adequate food and housing for their families. This may be especially true if those women who were still on welfare end up taking even lower-paying (and possibly less stable) jobs than women who have been able to leave welfare earlier and on their own accord.

Chapter 4

Health Status and Health Behavior

I. Introduction

Women in their childbearing years are generally in good health. About 92 percent of women age 18-44 described their health as good, very good, or excellent in the 1996 National Health Interview Survey (National Center for Health Statistics, 1999). However, given the level of economic disadvantage among the women in the Urban Change sample, they were expected to be less healthy than women nationally.

Several studies have documented health-related problems in the welfare population. For example, Loprest and Acs (1996) found, using 1991 data from the Survey of Income and Program Participation (SIPP), that 16.6 percent of the women who had received Aid to Families with Dependent Children (AFDC) at any point in the previous 32 months had a work limitation, and about 9 percent reported that they needed help with or were unable to perform specific functional tasks such as dressing, eating, bathing, or climbing stairs. These researchers also found that functional limitations were associated with longer welfare spells. Olson and Pavetti (1996) reported that in the 1991 National Longitudinal Survey of Youth (NLSY), nearly five times as many welfare recipients as nonrecipients (10.4 percent and 2.2 percent, respectively) said that they were not seeking work because of medical problems. More recently, using data from a random sample of welfare recipients in an urban Michigan county surveyed in 1997, Danziger et al. (2000) found that 19.4 percent had a physical health problem.

As described in Chapter 3, women in the Urban Change sample experienced extreme material hardships that could adversely affect their health. Material hardships can directly affect health because they expose people to unhealthy conditions such as nutritional and housing inadequacies, environmental hazards, and violence and aggression. Material hardships are also a source of stress, and stressful life experiences have repeatedly been found to adversely affect health[1] (Dohrenwend and Dohrenwend, 1981; Elliott and Eisdorfer, 1982; Linsky and Straus, 1986).

Material hardships and resulting stress also play a role in health behavior. For example, both cross-sectional and longitudinal studies have consistently shown that stress is related to greater food consumption, reductions in physical activity, and obesity (Greeno and Wing, 1994; Grunberg and Straub, 1992; Twisk, Snel, Kemper, and van Mechelen, 1999; Walcott-McQuigg, 1995). Stress has also been found to be related to smoking and smoking-related mortality (Colby, Linksy, and Straus, 1994; Twisk et al., 1999; Allison, Adlaf, Ialomiteanu, and Rehm, 1999; Anda et al., 1999). For example, in a longitudinal study of young adults, Twisk et al. (1999) found that changes in the number of daily stressful events over a two-year period were positively related to decreased physical activity and increased smoking. Thus, there is ample reason to expect that women in the Urban Change sample would be less healthy and would engage in less healthful behaviors than women in national samples.

---

[1] Stress and mental health outcomes in the Urban Change sample are discussed in Chapter 5.

There has also been considerable interest in the relationship between health and women's employment. As women's labor force participation increased over the past two decades, two competing theories emerged regarding how women's employment could affect their health. The *role strain* model predicts that role overload, resulting from women's need to juggle multiple responsibilities in the home and at work, would adversely affect health. On the other hand, the *role accumulation* model posits that employed women would have advantages because of increased self-esteem, personal gratification, and social support — as well as increased income. Studies have shown fairly consistently that employed women are healthier than nonworking women (Bird and Fremont, 1991; Ross and Mirowsky, 1995; Waldron and Jacobs, 1989), which undermines the role strain hypothesis.

However, the observed relationship leaves open the question of the underlying causal chain: Does health affect employment, or does employment affect health? As noted in Chapter 1, evidence from longitudinal studies suggests that both explanations have some empirical support, and reciprocal effects are also plausible. The longitudinal evidence seems to suggest strongly, however, that health is a more powerful and more direct determinant of employment decisions than vice versa, which is consistent with the conceptual model presented in Figure 1.1 (Chapter 1).

Taken together, these bodies of research lead to the expectation that women in the Urban Change sample who were working at the time of the interview would be healthier than women who were not working. This prediction is also consistent with findings in Chapter 3 indicating that employed women had significantly fewer material hardships than those who were not employed.

II. Physical Health Status

Physical Health Status: Highlights of the Findings

- On a widely used scale of physical health status, women in the Urban Change survey sample had less favorable scores than national samples of same-age adults.
- One-quarter of the survey sample rated themselves as being in fair or poor health, compared with only 8 percent of same-age women nationally.
- On all measures of health, including questions about physical limitations, women who worked, regardless of their welfare status, had more favorable outcomes than women who did not work.
- The ethnographic interviews indicate that some women faced serious health problems that could significantly impact their lives, and suggested that the survey data may understate health problems in this population.

The current health status of the women in the Urban Change survey was measured using the Short Form 12 Health Survey, commonly referred to as the SF-12. The SF-12 is a 12-item scale providing a generic, multidimensional measure of health status, and it has been used in numerous health studies.[2] The scale includes a measure of both physical health (discussed below) and mental health (discussed in Chapter 5). The instrument yields scores that have been standardized in a national sample to a mean of 50 and a standard deviation of 10. Scores below 50 indicate less favorable health status than that for a general adult population; the lower the standard score on the scale, the less favorable is the person's health status (Ware et al., 1996).

Table 4.1 presents the six indicators that make up the physical component of the SF-12 scale for the four work/welfare research groups. The first item is a widely used global self-assessment of health status.[3] Self-reported health has been validated as a measure of health status in several studies. For example, self-reported health had been found to be predictive of mortality (Miilunpalo, Vouri, Oja, and Pasanen, 1997; Mossey and Shapiro 1982) and has been correlated with both acute and chronic diseases (Ross and Mirowsky, 1995). As seen in Table 4.1, one-quarter of the women in the Urban Change survey sample rated their health as fair or poor. As a comparison, Figure 4.1 shows that only 7.7 percent of women age 18-44 nationally (21.1 percent of black women of all ages who were below the poverty level) assessed themselves as being in fair or poor health in 1996 (National Center for Health Statistics, 1999, Table 60). Conversely, only 18.6 percent of the women in the Urban Change sample, compared with 35.1 percent of U.S. women age 18-44 in 1996, rated their health as being excellent. Group differences in self-reported health status were significant: Women in the two working groups, regardless of welfare status, were less likely than nonworking women to rate their health as fair or poor. About twice as many women who neither worked nor received welfare (35.0 percent) as working former recipients (17.2 percent) perceived their health as fair or poor.

The remaining five items of the SF-12 physical component ask about specific health problems, such as pain and limitation of activity. Sizable minorities of women, ranging from 24 percent to over 40 percent, affirmed that they had one of the five specified problems. For example, 37.3 percent of the women indicated that their health limited moderate activities, such as moving a table or pushing a vacuum cleaner;[4] 44.1 percent said that their health limited their ability to climb several flights of stairs; and one out of four indicated that they experienced pain that interfered with normal work.

There were significant differences across the four work/welfare groups for all five items, and the differences persisted after controlling for background characteristics. The two working

---

[2] The SF-12 is a shortened version of the SF-36, a 36-item health survey developed from the Medical Outcomes Study. The SF-36 was widely used in research but was found to be too long for inclusion in many national surveys. Extensive research has documented the strong correspondence between the SF-12 and the SF-36. The SF-12 has been shown to have adequate reliability and validity in various populations and age groups (Ware, Kosinski, and Keller, 1996).

[3] Specifically, the question asks, "In general, would you say your health is excellent, very good, good, fair, or poor?"

[4] In comparison, 9.6 percent of women age 15-44 reported any kind of limitation of activity in the 1996 National Health Interview Survey. Less than 4 percent said they were limited in the amount or kind of any major activity (National Center for Health Statistics, 1999, Table 59).

The Project on Devolution and Urban Change

Table 4.1

Health Status of Respondents, by Work and Welfare Status[a]

Outcome	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Physical component of SF-12[b]					
Items (%)					
Reports fair to poor health	25.5 ***	17.2	20.0	32.1	35.0
Health limits moderate activities[c]	37.3 ***	28.5	33.8	44.3	44.1
Accomplished less than would have liked[d]	35.7 ***	25.3	32.1	44.3	43.0
Limited in the kind of work or other activities[d]	28.5 ***	19.5	24.1	36.0	36.2
Pain interfered with normal work[e]	24.8 ***	19.1	20.5	28.9	34.4
Health limits climbing several flights of stairs	44.1 ***	37.2	41.9	50.5	45.7
Mean score	46.9 ***	49.1	48.0	45.2	44.7
Scored less than 40 (%)	31.2 ***	21.9	24.3	39.4	40.6
Health condition limits kind or amount of work (%)	24.0 ***	11.6	15.7	34.1	37.9
Currently receives disability income (%)	8.7 ***	3.1	6.1	12.5	15.8
Sample size	3,765	1,240	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[c] For example, moving a table.

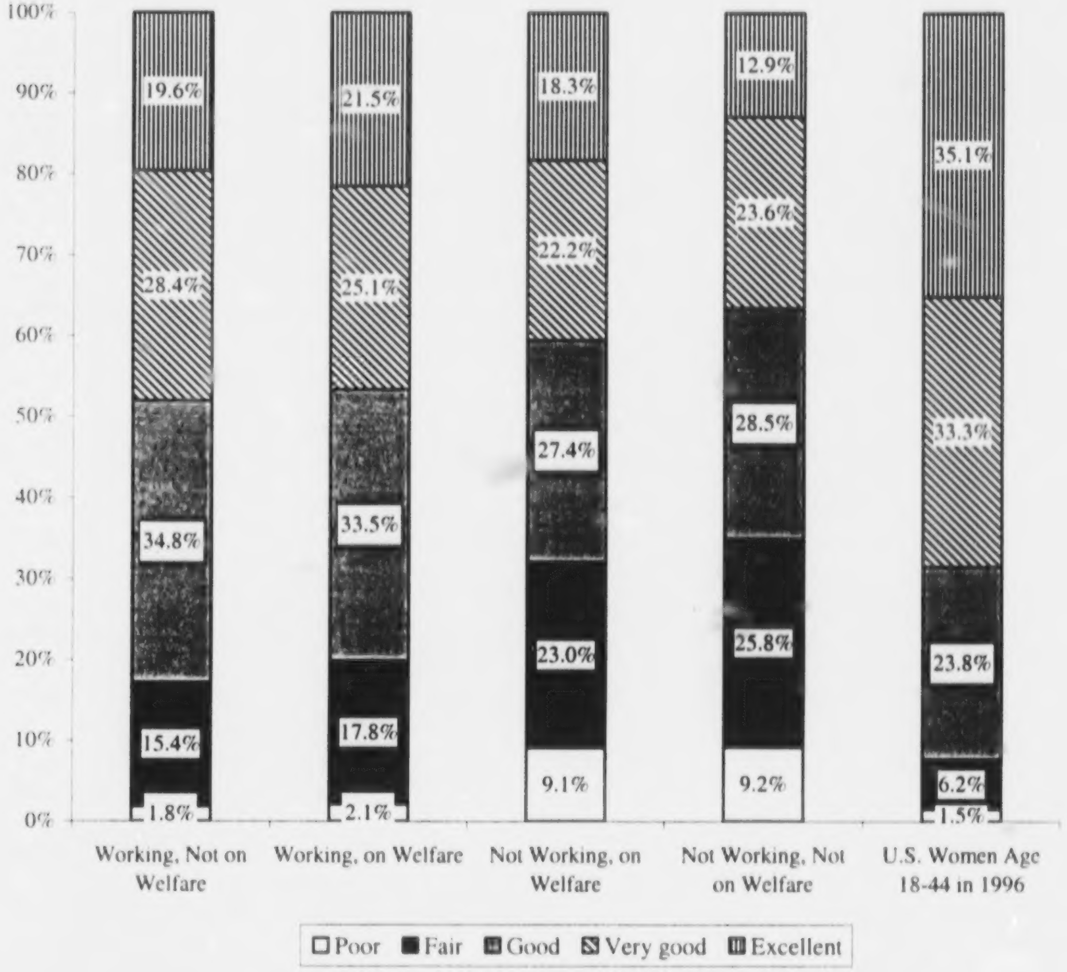
[d] In the past four weeks.

[e] This includes housework in the past four weeks.

The Project on Devolution and Urban Change

Figure 4.1

Self-Reported Health Status, by Work and Welfare Status[a] and in U.S. Population



SOURCE: MDRC calculations from the Urban Change Respondent Survey; Centers for Disease Control/National Center for Health Statistics, 1999, Table 70.

NOTE: [a]Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

groups, especially women who had left welfare, had consistently lower rates of health limitations than nonworking women. For example, 11.6 percent of the employed former recipients and 15.7 percent of the employed current recipients reported that they had a physical problem that limited their work or type of work, compared with over one-third of the women in each of the two nonworking groups. On all SF-12 physical items, women who worked and had left welfare were somewhat better off than employed recipients.

For the overall SF-12, the mean physical component standard score for women in the Urban Change survey sample was 46.9, which is lower than the mean of 50 for the general U.S. population; more notably, it is below the mean of 52.8 for similar-age adults (18-44) nationally (Ware et al., 1996). Within the four work/welfare groups, the means ranged from a low of 44.7 for nonworking welfare leavers to a high of 49.1 for working welfare leavers. Thus, the mean score for even the healthiest group of women in Urban Change was lower than the average for same-age adults nationally.

In the Urban Change study, women were considered to have special health vulnerabilities if their SF-12 physical score was under 40. This score was used as a criterion of poor health because it is one full standard deviation below the national mean of 50, meaning that only 16 percent of the adult U.S. population have such unfavorable scores. In the Urban Change sample, nearly one-third of the women had a score of less than 40. By contrast, only about 10 percent of adults age 18-44 nationally have such low scores.[5]

Figure 4.2 presents score ranges on the SF-12 for the Urban Change sample (by work/welfare status) as well as for adults age 18-44 nationally. People with scores below 40 are substantially less healthy than the general adult population nationally, and those with scores of 60 or more are considerably healthier. As seen in the figure and in Table 4.1, the two groups of employed women in the Urban Change survey sample, regardless of welfare status, were significantly less likely to have poor physical health scores than women in the two groups of nonworkers. For example, 15.6 percent of former recipients who worked had an SF-12 physical score less than 40, compared with 31.6 percent of nonworking current recipients. However, and perhaps most important, all four work/welfare groups fared less favorably when compared with a national sample of adults age 18-44, as shown by the right-hand bar in Figure 4.2.

Women in the Urban Change survey sample were also asked whether they had a health condition that limited the kind or amount of work they could do. Overall, 24.0 percent reported having such a health condition. Table 4.1 shows that over one-third of the nonworking women said that health limited their work, while substantially smaller percentages of women in the work-only group (11.6 percent) and in the work-and-welfare group (15.7 percent) reported such a problem.

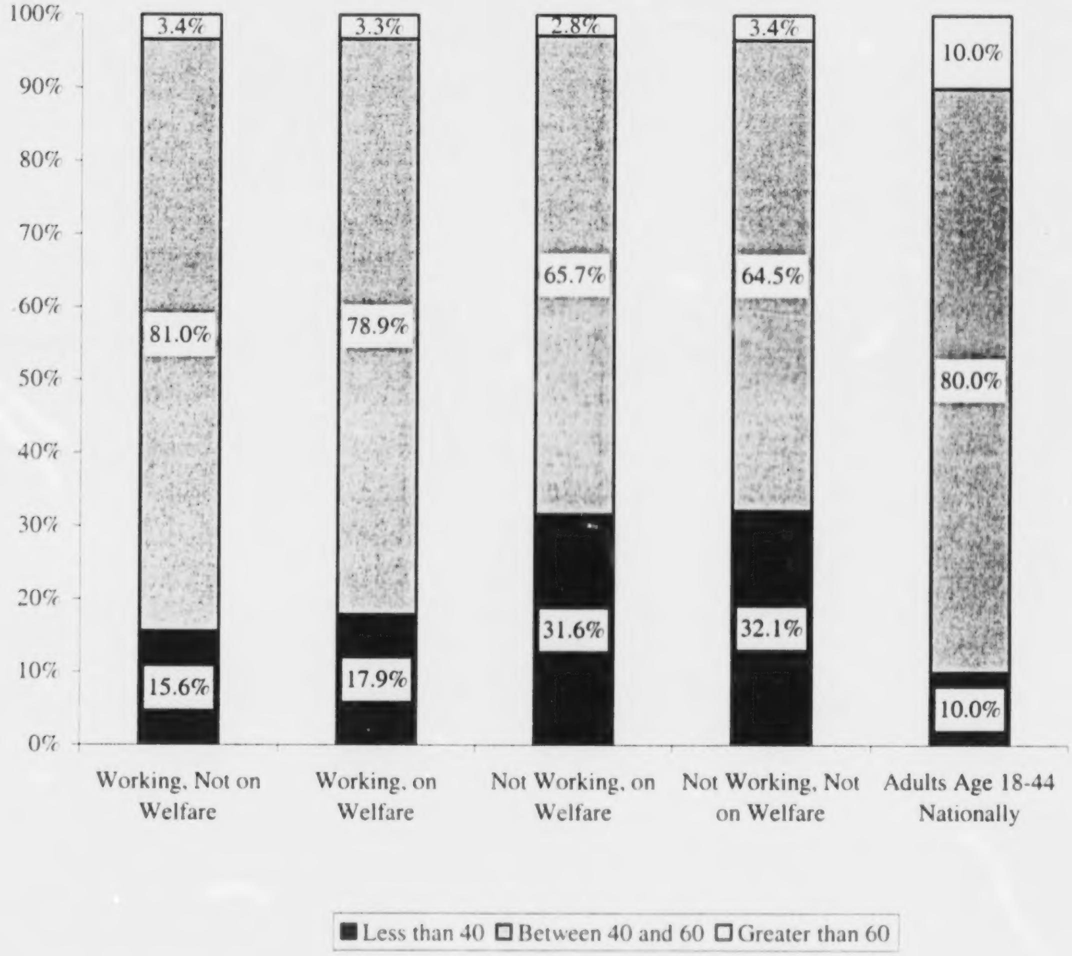
---

[5] This percentage was estimated by using the mean score (52.8) for men and women age 18-44 and assuming that the standard deviation for this age group was the same as that for the general population (10). Then, a z score was computed to estimate the percentage who had a score below 40. However, it should be noted that the national sample includes both men and women and that, across all age groups, average scores on the SF-12 are lower for men than for women; thus, the mean standard score for *women* age 18-44 would likely be higher than 52.8. That is, it is likely than even fewer than 10 percent of women in this age range nationally would score below 40. However, information was not available regarding scores for men and women according to age ranges.

The Project on Devolution and Urban Change

Figure 4.2

Score on Physical Component of SF-12, by Work and Welfare Status[a] and in U.S. Population



SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE: [a]Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

One final health outcome measure was the receipt of disability income (Supplemental Security Income, or SSI). Once again, a similar pattern emerged. Compared with women in the two nonworking groups, a much lower proportion of women in the working groups (regardless of welfare status) reported receipt of disability income for themselves in the prior month. This is consistent with the presumption that someone who is able to work for pay would likely not be eligible for disability payments.

Just as most survey respondents rated their health as good to excellent, women in the ethnographic sample, when directly asked by an interviewer how they would describe their health, mostly said that their health was "good." However, several respondents said they were in good health until the interviewer probed for health problems. Once the interviewer probed, these women provided a wealth of detail about various health problems that had plagued them. The following is an excerpt from an interview with a woman from Cleveland who, when asked directly, stated she was in "pretty good" health; then the interviewer asked a follow-up question:

> [Interviewer:] *Tell me a little about the injury.*
> [Respondent:] *I was standing on the third shelf, I was pulling the fourth one up. The guy they gave me to help was stronger. Lost my footing, smashed my ankle into the shelf that I was standing on. A gangloid cyst tumor developed in the soft tissue. It started growing through the tendons and the nerves before they okayed the surgery. And now I have nerve damage, partial nerve damage to the foot from that. . . . I injured it in August, they finally okayed the surgery in October.*

As the interviewer continued to probe, this woman revealed further health problems:

> [Interviewer:]. *You said you had also injured your back before. Is that better?*
> [Respondent:] *No, it's not better, but I just keep going. I don't let it get me down. Even the asthma, I don't let it stop me.*
> [Interviewer:] *Do you have asthma, too?*
> [Respondent:] *Yeah. So I just keep going. I mean, I try not to think about it. . . . I just got over a really bad case of bronchitis. And I've seen him [the doctor] a couple times. I just had breast surgery done in May. They removed a cyst. Thank God it wasn't cancerous.* Wendy, Cleveland

A woman in Philadelphia who said her health was good later admitted that she had been to the doctors for some tests because they suspected she had cervical cancer. However, she did not return to learn the test results. Yet another woman, in Miami, brought up her recent diagnosis of leg cancer when asked a general question about her current situation. She mentioned this in the context of having to delay entry to a training program. However, when the interviewer had asked her to describe her health, she stated, "I'm very healthy." Thus, the ethnographic data suggest that a single, direct question about health status may mask health problems in this population that are revealed only through in-depth discussions that are not necessarily focused on health issues.

Some women in the ethnographic sample discussed medical problems that are fairly common, such as asthma. However, some of the health-related issues mentioned were problems that could significantly impact the lives of these women. Several respondents described serious medical conditions that would not only make it difficult to function at work or at home but that were, in some cases, debilitating:

> *Physically, I got chronic bronchitis and that is a form of asthma and I am also diabetic.* Lisa, Philadelphia
>
> *I fell and got two fractures in my foot and the bruise on the back of my leg which it ended up into like a big blood clot as big as a hospital . . . [and was diagnosed with] chronic anemia.* Margaret, Philadelphia

This respondent's blood clot in her foot forced the removal of the cast, despite the fracture.

One Los Angeles woman described both vision problems and weakness in her arm that she attributed to a childhood bout with polio:

> *That's right. I may drop or break things I handle. . . . I have very poor sight in one of my eyes. . . . I was told I am blind in one of my eyes. Prescription glasses will not help this eye at all.* Da, Los Angeles

Another woman from Los Angeles recounted:

> *Sometimes I have chest pain. Other times, I have dizzy spell. I am bleeding when I have a bowel movement.* Phoeun, Los Angeles

Respondents in Miami also mentioned health-related problems:

> *I have had this problem of the thyroid for many years. In Santo Domingo they told me it is very dangerous.* Juliana, Miami
>
> *I went in the hospital the other night, and when I went to the emergency room the doctor took three hours [to see me]. . . . I went down there with high blood pressure and heart symptoms. . . . Fever, chest pains, sweats. This pain has been going on for about a month and a half.*[6] Marsha, Miami

As evidenced by these excerpts, a number of women faced health problems that could have implications for entry to the labor market.

III. Health Behavior

A person's health can be affected by a number of factors, including health care access and quality, genetic traits, and material hardships. Health can also be affected by people's habits and lifestyles — by such health-promoting behaviors as maintaining an exercise regimen and getting sufficient sleep and also by behaviors that place them at greater risk of serious illness. Two risk behaviors with clear-cut health implications are smoking and being overweight. Such behaviors are, to some extent, under people's control. However, many other factors contribute to health-related behaviors, including cultural forces (for example, dietary choices) and social forces (such as peer pressure to smoke cigarettes or to drive at high speeds). Moreover, as noted earlier in this chapter, there is growing evidence that health-risk behaviors are partly determined by stress and stressful life circumstances such as those described in Chapter 3.

---

[6] This respondent was diagnosed with angina.

Health Behavior: Highlights of the Findings

- The prevalence rate of smoking among women in the Urban Change sample was much greater than the national smoking rate.
- Former recipients who worked were the least likely to report smoking, while nonworking recipients were the most likely.
- Nonworking current recipients were more likely to be morbidly obese than women in the other three work/welfare groups.
- Former recipients who worked were the least likely to be obese smokers.

The next two sections examine two important health-risk behaviors: smoking and obesity. Drug and alcohol use are discussed in Chapter 5.[7]

A. Smoking

Smoking cigarettes is considered the most preventable cause of morbidity and mortality in the United States (Centers for Disease Control tobacco Web site). Smoking has long been linked to a host of negative health outcomes both for smokers and, through passive smoking, for children and other household members. Negative outcomes include cancer, cardiovascular disease, chronic obstructive pulmonary disease, reduced fertility, spontaneous abortion, ectopic pregnancy (Mueller, 1998), and cervical abnormalities (Scholes et al., 1999). There is also evidence that smokers have higher rates of absenteeism from work than nonsmokers (Ryan, Zwerling, and Jones, 1996; French, Zarkin, Hartwell, and Bray, 1995). Furthermore, it is estimated that 8,000 to 26,000 new cases of asthma in children are caused by mothers who smoke more than 10 cigarettes a day and that, each year, between 200,000 and 1 million children's asthma conditions will be worsened by exposure to "secondhand" smoke (Centers for Disease Control tobacco Web site).

Respondents to the Urban Change survey were asked whether they currently smoked cigarettes (see Table 4.2). Overall, 39.8 percent of respondents reported smoking. In comparison, the 1993-1995 prevalence rate for smoking by women age 18 or older was 24.2 percent for whites, 22.2 percent for African-Americans, and 14.4 percent for Hispanics (National Center for Health Statis-

---

[7] The survey did not, unfortunately, include questions about health-promoting behaviors such as exercise.

The Project on Devolution and Urban Change

Table 4.2

Health Behavior of Survey Respondents, by Work and Welfare Status[a]

Outcome	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Currently smokes cigarettes (%)	39.8 ***	32.2	39.9	44.9	44.1
Average BMI score[b] (%)	28.7 *	28.5	29.0	29.0	28.0
Morbidly obese	7.1 **	5.6	6.6	9.1	5.4
Obese	29.1	28.2	32.9	28.2	28.3
Overweight	29.9 *	33.5	28.3	28.0	29.0
Within ideal weight range	32.0	31.5	31.1	32.4	33.9
Below ideal weight range	1.9 *	1.3	1.2	2.3	3.4
Currently smokes cigarettes and is obese (%)	13.3 ***	9.8	15.1	14.9	15.6
Sample size	3,764	1,239	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except: "Average BMI score," "Overweight," and "Below ideal weight range." The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

tics, 1999, Table 63).[8] There were significant group differences in smoking rates, which persisted after controlling for the respondents' background characteristics. Approximately 44 percent of respondents in the two nonworking groups reported smoking. The proportion who smoked in the group of working former recipients was nearly 12 percentage points lower (32.2 percent).

B. Weight

Obesity, like cigarette smoking, has been linked to numerous health problems, including hypertension, increased risk of coronary heart disease, and the development of non-insulin-dependent (type II) diabetes (Bray, 1996; James, 1998). The risk for these health problems has been found to increase as the degree of obesity increases (Thompson, Holcomb, Loprest, and Brennan, 1998).[9] Furthermore, the risk of death for both men and women from such causes as cardiovascular disease, cancer, and other diseases increases throughout the range of moderate and severe overweight (Calle et al., 1999). It has been estimated that 4 percent to 6 percent of all direct health care costs in the United States are attributable to obesity (Allison, Zannolli, and Narayan, 1999). Obesity, like smoking, has been found to be associated with higher rates of absenteeism from work (Tsai et al., 1997; Tucker and Friedman, 1998).

In the past decade, the proportion of adults age 20 and older in the United States who met the criteria for being either overweight or obese had increased to nearly 55 percent (National Heart, Lung, and Blood Institute Web site). At least one-third of Americans are obese, with rates being particularly high among women and nonwhites (Solomon and Manson, 1997).

The measure most often used as an index of weight is referred to as the body mass index, or BMI. Calculated utilizing a person's weight and height,[10] the BMI is a measure of body fat, which has been found to be correlated with morbidity and mortality in many epidemiologic studies (National Heart, Lung, and Blood Institute Web site). Generally, a score between 18.5 and 25 on the BMI is considered to be within the ideal weight range, while a score of less than 18.5 is considered underweight. People with BMI scores between 25 and 30 are defined as overweight, and those with scores over 30 are defined as obese. Morbid obesity, which is considered to place people at especially high risk for health problems and premature mortality, is usually defined as a BMI greater than 40.

Utilizing self-reported measures of weight and height from the Urban Change survey, BMI scores were calculated for the women in the survey sample. As shown in Table 4.2, the average BMI for all respondents was 28.7, indicating an average value in the overweight range. Though the average BMI varied across the four work/welfare groups, the differences were modest, ranging from a low of 28.0 for women in the no-work, no-welfare group to 29.0 for both groups of current recipients; these mean group differences were no longer significant when background differences were controlled.

---

[8] Smoking prevalence rates vary by income and education as well as by race/ethnicity, and higher rates are associated with lower income and less education. For example, 20.3 percent of African-Americans with 13 years or more of education smoked, compared with 31.5 percent of those without a high school diploma (National Center for Health Statistics, 1999, Table 63).

[9] However, there is evidence that obesity is a lower risk factor for mortality among African-American women than among white women (Stevens et al., 1998, Durazo-Arvizu et al., 1998; Calle et al., 1999).

[10] Specifically, a person's BMI is equal to weight in kilograms divided by the square of his or her height in meters.

However, the average BMIs mask some differences in the distribution of weight categories. In particular, the proportion of women classified as morbidly obese ranged from just over 5 percent for women in the two former-recipient groups, compared with nearly twice that (9.1 percent) for current welfare recipients who were not working. Group differences in morbid obesity remained significant even with background characteristics controlled. Interestingly, women in the two nonworking groups were more likely than employed women to be *under*weight.

Researchers have also investigated the relationship between smoking, obesity, and health outcomes. Findings related to the additive effect of the two risk factors of smoking and obesity have not been consistent, but some studies have found that smoking elevates the risk of early mortality among those at either extreme of the weight distribution (Lee et al., 1993; Bender, Trautner, Spraul, and Berger, 1998). Table 4.2 shows that 13.3 percent of the women in the Urban Change survey sample were smokers who were obese (that is, had BMI scores of 30 or higher). Significant group differences emerged; the group of working former recipients had the lowest proportion of obese smokers (9.8 percent).

IV. Relationship Between Health Status and Measures of Material Hardships and Health Behaviors

Health Correlates: Highlights of the Findings

- Women in fair or poor health were significantly more likely than those in better health to be food insecure, to have been homeless or sheltered in the previous year, and to have multiple material hardships.
- Women in fair or poor health were more likely than women in better health to smoke, to be obese, and to be obese smokers.

As mentioned in Chapter 3, food security and material hardships have implications for a person's health and well-being. This section discusses the relationship between physical health, on the one hand, and measures of both material hardships and health behaviors, on the other.

Table 4.3 compares women who reported that they were in good, very good, or excellent health with those who said they were in fair or poor health. In general, material hardships were associated with poorer health. As Table 4.3 indicates, women in fair or poor health were significantly more likely than healthier women to be food insecure; food insecurity was experienced by nearly 60 percent of those who reported they were in fair or poor health, compared with 45.1 percent among those in good or excellent health. About twice as many of the women in the less healthy group (24.8 percent) as those in better health (12.6 percent) had experienced hunger (not shown). Women who rated themselves as being in fair or poor health were also significantly

144

The Project on Devolution and Urban Change

Table 4.3

Selected Material Hardship and Health Behavior Outcomes, by Self-Reported Health Status

Outcome (%)	Excellent to Good Health	Fair to Poor Health
Food insecure[a]	45.1 ***	59.8
Has 2 or more housing problems[b]	23.1 ***	34.4
Lived in emergency shelter or was homeless in past 12 months	2.3	2.9
Has 3 or more material hardships[c]	24.7 ***	39.2
Obese[d]	34.1 ***	42.4
Currently smokes cigarettes	37.0 ***	47.7
Currently smokes cigarettes and is obese	11.2 ***	19.2
Sample size	2,700	923

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[b] Respondents indicated whether they had any of the following housing problems: broken windows, leaky ceilings, roaches/vermin, and problems with wiring, plumbing, heating, and appliances.

[c] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[d] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

more likely than healthier women to have two or more housing hardships (for example, electrical problems, heating problems, vermin); to have been homeless or sheltered in the previous year; and to have three or more material hardships. In short, these findings are consistent with prior research that has found that material hardships contribute to poor health outcomes — although, because of the cross-sectional nature of these data, it is also possible that poor health contributed to material hardships in this population (for example, by interfering with employment that could increase family income).

Table 4.3 also presents information on the relationship between health status and health behaviors. Respondents reporting fair or poor health were significantly more likely to be obese (42.4 percent) than those reporting good or excellent health (34.1 percent). Nearly twice as many women who reported fair or poor health (11.5 percent), in comparison with those in better health (5.9 percent), were morbidly obese (not shown). Women who rated their health more poorly were also significantly more likely to smoke than those with better health ratings (47.7 percent versus 37.0 percent, respectively). Some 19.2 percent of those in poorer health both smoked and were obese, compared with 11.2 percent among healthier women. Again it should be noted, however, that it is not possible to determine from these cross-sectional data whether the outcome (obesity, smoking, or obesity and smoking) was a contributing factor to self-reported health status.

V. Discussion

Overall, the women in the Urban Change survey sample were considerably less healthy than national samples of adults. Furthermore, women's employment and welfare status were significantly related to virtually all measures of health. On measures of physical health, the two working groups, regardless of welfare status, fared better than the two nonworking groups. These group differences persisted even after controlling for background differences, meaning that they do not merely reflect those characteristics often associated with health variation, such as education, race/ethnicity, and marital status. Among nonworking women, current recipients and former recipients had comparably unfavorable health outcomes.

It seems possible that, as the welfare time limits take effect, some of the recipients with health problems may find it quite difficult to transition to employment. Moreover, even among the women who were employed at the time of the interview, health problems and limitations were far more prevalent than in a general population. This, in turn, leads to concerns about the ability of women with health problems to sustain regular, full-time employment — while at the same time raising their children and managing their households.

The ethnographic data suggest the possibility that health problems might have been underrated and underreported in the survey. In the ethnographic interviews, many women initially stated that they were in good health, but they subsequently described a host of medical problems either when the interviewer probed or when discussing other aspects of their lives. The ethnographic interviews also revealed that many of the women's health problems were chronic (for example, severe asthma, weak limbs) and serious (for example, cancer, heart problems). These health conditions could lead to challenges in entering the labor market.

Finally, outcomes that could be considered risk factors for subsequent poor health also played an important role in this sample. The proportion of respondents who were considered overweight or obese was nearly 10 percentage points greater than national rates. The prevalence rate for smoking in this sample was nearly 17 percent higher than the national sample. These behaviors could put these women at higher risk for persistent, ongoing health problems — problems that could interfere with their ability to work.

Chapter 5

Mental Health

I. Introduction

Mental health is an important public health concern that has implications for women's employment and their reliance on public assistance and, thus, for society overall. The Surgeon General's office estimates the current prevalence of mental disorders during a given year at about 20 percent of the U.S. population. Furthermore, in 1996, the direct costs of mental health services in the United States totaled $69 billion (Surgeon General's Report, 2000).

Studies based on samples of the general population consistently document that there is a strong association between mental health status and socioeconomic circumstances. Lower levels of income, educational attainment, and occupational prestige are consistently associated with higher levels of subclinical emotional distress and various mental health disorders, including substance abuse disorders (Blazer, Kessler, McGonagle, and Swartz, 1994; Kessler et al., 1994; Mutaner et al., 1998; Turner, Wheaton, and Lloyd, 1995). Consistent with this epidemiological profile, high levels of emotional distress and depression are commonly observed in studies of low-income populations and among welfare recipients (Danziger, Corcoran, Danziger, and Heflin, 1999; Delva and Kameoka, 1999; Legal Action Center, 1999; Quint, Bos, and Polit, 1997; Schmidt, Weisner, and Wiley, 1998; Speiglman, Fujiwara, Norris, and Green, 1999). For example, Lynch, Kaplan, and Shema (1997) found that the likelihood of clinical depression was more than three times higher among persons whose incomes were lower than 200 percent of the poverty level than among persons with higher incomes.

A dominant conceptual framework for understanding how social conditions affect health is referred to as the *stress paradigm*. According to this model, stress is an internal response to acute or chronic social and environmental stressors (for example, material hardships, the death of a loved one). Prolonged or multiple exposures to stressors in the absence of adequate psychological and social resources (that is, coping mechanisms and social support) to manage and minimize the experience of stress exacts a toll on the body, causing physical and mental health problems (Aneshensel, 1992; Turner et al., 1995; Pearlin, 1989; Thoits, 1995). Differential exposure to stressors, differential resources for buffering the effects of stressors, and differential vulnerabilities to stressors across subpopulations account for substantial differences in rates of physical and emotional distress and disorder. As shown in Chapter 4, the physical health outcomes of women in the Urban Change survey sample were worse than national averages, were lower among working women (than among women who received welfare or who neither worked nor received welfare), and were higher among those experiencing greater material hardships. It is expected that similar results will be found for mental health and substance abuse outcomes. Moreover, since there is substantial comordidity with respect to physical and mental health problems and substance abuse, it is also expected that these outcomes will be related to one another.

In the current context of welfare reform, there is considerable interest in the extent to which mental health problems — including alcohol and drug abuse and domestic violence — will affect the ability of women to transition from welfare to work and to sustain work (Legal

Action Center, 1999; Speiglman et al., 1999). Recent evidence from a study of welfare recipients in an urban Michigan county indicates that major depression significantly reduced the accumulation of work experience over time (Danziger et al., 2000).[1]

This chapter describes the mental health, substance use, and domestic violence experiences of women in the Urban Change survey and ethnographic samples. Domestic violence is included because of its well-documented link with poor mental health outcomes. In addition to describing the differences among women according to work/welfare status, this chapter will examine the relationships between material hardship and physical health outcomes, on the one hand, and the risk of depression, on the other.

II. Mental Health

Mental Health: Highlights of the Findings

- One-third of the Urban Change survey sample had unfavorable scores on a standardized measure of emotional well-being, compared with 16 percent of adults age 18-44 nationally.
- Half the women in the Urban Change sample were at moderate or high risk of depression.
- Working respondents — especially those no longer on welfare — had more favorable mental health outcomes than nonworking women.
- About half the full sample reported feeling highly stressed in the month prior to the interview; former recipients who worked were the least likely to report high stress.
- The ethnographic data suggest that stress was an especially salient issue for these women; one of the sources of stress mentioned by some respondents was the pressure of welfare reform itself.

As mentioned in Chapter 4, the Short Form 12 Health Survey, or SF-12, was administered to survey respondents to assess their physical health and their mental health.[2] Scores on the scale are standardized using the general U.S. population to a mean of 50 and a standard deviation of 10; *lower* scores indicate *less favorable* mental health outcomes. Examples of questions from the SF-12 scale that address mental health functioning include: "During the past four weeks, as a result of any emotional problems, did you not do work or other activities as carefully as usual?" and "How much of the time during the past four weeks have you felt downhearted and blue?"

---

[1] The weight of the evidence indicates that mental health problems, particularly clinical depression, influence employment outcomes. However, there is also evidence relating to the beneficial effects of employment on well-being (especially self-esteem), but this evidence suggests that such effects are likely to vary with the types of jobs women take. Research has indicated that jobs that are high in demands, high in routinization, and low in substantive complexity and decision latitude (that is, self-direction) are experienced as more stressful than jobs with other characteristics (Karasek and Theorell, 1990; Roxburgh, 1996). Since the low-wage jobs that welfare recipients are most likely to get are also likely to have these stress-producing characteristics, it is plausible that these job conditions might counteract some or all of the psychological benefits (such as, improved self-esteem and reduced stigmatization) that women expect to be associated with leaving welfare for work (Scott, Edin, London, and Mazelis, forthcoming).

[2] As described in Chapter 4, the SF-12 is a shortened version of the SF-36, a 36-item health survey developed from the Medical Outcomes Study. The SF-12 has been shown to have adequate reliability and validity across various populations and age groups (Ware, Kosinski, and Keller, 1996).

It is important to note that the mental component of the SF-12 does not assess for a particular mental health problem, such as depression, but rather for general mental health functioning. However, the relationship between SF-12 mental component scores and mental health problems has been previously established. For example, Sugar and colleagues (1998) stratified a sample into categories of depression and found a relationship between depression and scores for the SF-12 mental component.[3] Those categorized as sub-threshold for depression, for example, had a mean score of 44.4 on the SF-12 mental component, and those categorized as having current major depression had a score of 37.4 (Sugar et al., 1998).

As shown in Table 5.1, the mean score on the SF-12 mental component for the Urban Change survey sample was 47.1, compared with a mean score of 49.6 for the general U.S. population age 18-44 (Ware et al., 1996). While the difference is not large, it does indicate that this sample of women had less favorable mental health scores than the general population of same-age adults.[4]

Over one-quarter (25.5 percent) of the Urban Change sample had especially unfavorable scores (less than 40) on the mental component of the SF-12.[5] In comparison, an estimated 16 percent of adults age 18-44 nationally have a score below 40, that is, about half the rate of the Urban Change sample (see Figure 5.1).[6] Moreover, using the SF-12 score of 37.4 — the average score among those with major clinical depression in the Sugar et al. (1998) study — 20.0 percent of the women in the Urban Change survey sample scored below this level on the SF-12.

Significant group differences emerged in the mental component of the SF-12, and they remained significant even after controlling for background characteristics. As shown in both Table 5.1 and Figure 5.1, working women, especially if they had left welfare, had more favorable mental health scores than women who were not working. For example, former recipients who worked had a mean score of 49.1, compared with a score of 45.4 for current recipients who did not work. Only 17.9 percent of the former group, but 31.9 percent of the latter group, had SF-12 scores below 40.

---

[3] The researchers used a two-stage process to assess depression. In the first stage, a depression screening form was used. In the second stage, the criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-III) was used to determine the presence of clinical depression among those who had been screened as being "at risk."

[4] The SF-12 scale, along with virtually all measures in this chapter, was included in a self-administered questionnaire, so that survey respondents would have greater privacy in responding to sensitive questions. A total of 90 respondents did not complete the questionnaire, but there were almost no differences between completers and non-completers in terms of background characteristics and health outcomes (see Appendix A).

[5] A score of 40 was used as the criterion of poor mental health because it is one standard deviation below the national mean of 50 on this scale.

[6] This percentage was estimated by using the mean score for adults age 18-44 (49.6) and assuming that the standard deviation for this age group was the same as that for the general population (10). Then, a z score was computed to estimate the percentage with a score below 40.

The Project on Devolution and Urban Change

Table 5.1

Mental and Emotional Health Indicators, by Work and Welfare Status[a]

Outcome	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Mean score on mental component of SF-12[b]	47.1 ***	49.1	47.6	45.4	46.0
Scored less than 40 on mental component of SF-12[b] (%)	25.5 ***	17.9	23.1	31.9	30.0
Mean score on CES-D scale	17.6 ***	15.1	16.9	19.5	19.5
Risk of depression[c] (%)					
None	50.1 ***	59.8	51.1	43.0	45.2
Moderate	22.6 **	20.3	25.3	24.3	20.0
High	27.2 ***	19.9	23.6	32.7	34.8
Felt highly stressed much or almost all the time, past month (%)	50.1 **	46.1	53.2	52.0	50.3
Sample size	3,765	1,240	626	1,468	431

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

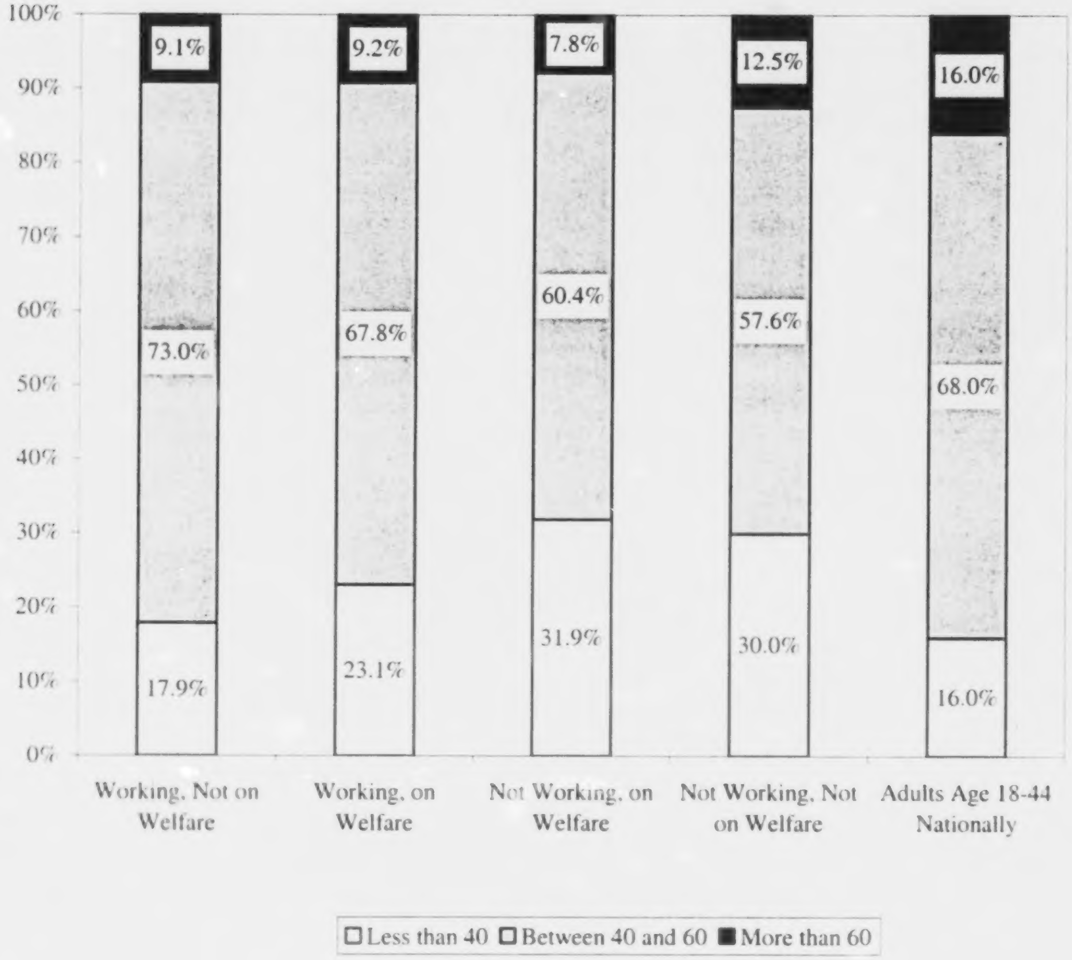
[b] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[c] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

The Project on Devolution and Urban Change

Figure 5.1

**Score on Mental Component of SF-12,
by Work and Welfare Status[a] and in U.S. Population**



SOURCES: MDRC calculations from the Urban Change Respondent Survey;
Centers for Disease Control/National Center for Health Statistics, 1999, Table 70.

NOTE: [a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

However, as shown in Figure 5.1, even women in the work-only group were more likely than same-age adults nationally to have scores below 40 (17.9 percent versus 16.0 percent in the national sample) and were far less likely to have scores of 60 or above (9.1 percent versus 16.0 percent).

Another measure used to assess the emotional well-being of this sample was the Center for Epidemiological Studies-Depression (CES-D) scale. The CES-D is a 20-item scale that asks questions related to mood and functioning in the prior week. It is a widely used research instrument for measuring symptoms of depression.[7] The CES-D has been found to be highly reliable — .85 in the general population, .90 in a patient sample (Radloff, 1977), and .89 in the current study. Examples of items contained in the scale include: "During the past week, I thought my life had been a failure" and "During the past week, I felt depressed."

CES-D scores, which range from 0 through 60, are used to indicate the *risk* of depression. Generally accepted cutoffs for the scale are as follows: A score less than or equal to 15 indicates low risk of depression, a score between 16 and 23 is considered moderate risk of depression, and a score above 23 is considered high risk of depression. It is important to note that the CES-D is a research instrument, not a clinical measure; it assesses whether the respondent is at *risk* of depression rather than whether a *diagnosis* of depression exists (McDowell and Newell, 1996).

As shown in Table 5.1, the mean CES-D score for the women in the Urban Change survey was 17.6, indicating that, on average, these women were at moderate risk of depression.[8] The scores for women in the survey sample ranged from 0 to 60 — that is, the full theoretical range. Overall, half the women in the sample were at some risk of depression; 22.6 percent were at moderate risk, and 27.2 percent were at high risk.[9] There were significant differences across the four work/welfare groups, even after controlling for background differences. As seen in Table 5.1, employed former recipients had the most favorable average CES-D score (15.5). Women in the three remaining groups all had mean scores indicating moderate risk of depression; current recipients who were not working had the highest mean score (19.5).[10] Nevertheless, it is noteworthy that more than 40 percent of the women in the work-only group — the group with the best outcome — were at risk of depression and that one out of five was at high risk.

Women were also asked about their levels of stress.[11] Table 5.1 also shows that half the women in the survey sample reported feeling highly stressed during the month prior to the interview.[12] The group differences that emerged were consistent with the patterns observed for the SF-12 and CES-D: Fewer women who were working and had left welfare (46.1 percent) reported stress than women in other groups. The group most likely to report feeling stressed was working recipients (53.2 percent), perhaps reflecting the pressures of combined obligations — that is, raising a family, keeping up with the requirements of welfare, and having a job. However, a similar proportion of nonworking recipients (52.0 percent) reported feeling stressed in the past month; many women in this group also faced multiple obligations as a result of new participation requirements.[13]

---

[7] The CES-D has been validated in many studies and in varied populations, and it has also been used effectively in community cohorts as a screening device (see, for example, Comstock and Helsing, 1976; Radloff and Locke, 1985).

[8] The correlation between scoring less than 40 on the SF-12 mental component and being at moderate or high risk of depression (that is, scoring higher than 16 on the CES-D) was .43 ($p < .001$).

[9] As a comparison, Danzinger and colleagues (2000) found, in their study of welfare recipients in an urban Michigan county, that 25 percent of their sample had a major depressive disorder. A recent MDRC study of the Minnesota Family Investment Program (MFIP) found that the mean CES-D score for women on AFDC was 19.0 and that 31.6 percent of these women were at high risk of depression (Knox, Miller, and Gennetian, 2000).

[10] This result is similar to that of another study, which found that, among a cohort of African-Americans, one of the groups most at risk of depression was unemployed women looking for work while receiving government benefits (Rodriguez, Allen, Frongillo, and Chandra, 1999).

[11] Specifically, survey respondents were asked, "How much of the time during the past month would you say you felt highly stressed — none of the time, some of the time, much of the time, or almost all of the time?" A response of "much" or "all" of the time was used as the indicator of stress. The correlation between this measure of stress and

(continued)

Women in the Urban Change ethnographic sample were also asked about their mental health. Most interviewers used such questions as "How would you describe your mental health?" or "How has your mental health been?" A few women mentioned nervous breakdowns and severe mental health problems, some of which had required hospitalization. For example, one woman in Miami described how she had tried to commit suicide when she was 12, had spent her next birthday in a mental institution, and had been in and out of hospitals throughout her teenage years. This woman, who had been raped and otherwise abused as a child, continued to experience psychological distress, although it was carefully controlled by medication at the time of the interview.

However, women were more likely to mention less extreme forms of emotional difficulty. Some respondents specifically mentioned feeling depressed:[14]

> *I'm depressed often. My mother doesn't help a lot, because from her I get the I-work-all-day thing and that makes me even more depressed because I'm not working and I get from her the I'm-taking-care-of-your-daughter, so that makes me feel like I'm a bad mother. So, yeah, I'm depressed quite often. Quite often.* Brenda, Cleveland

> *I get a little depression sometimes when I'll just sleep, you know and get it over with and then tomorrow's another day. You know, I try not to take it out on anybody else and, you know, try not to let [my daughter] know. But yeah, it gets depressing once in awhile, the thought of the way life is nowadays. But we all gotta go on.* Gayle, Cleveland

> *Yes, sometimes I feel a little, well, I assume it's normal, but sometimes I feel a bit depressed. Sometimes it's not because of anyone, it's within myself.* Juliana, Miami

---

scores below 40 on the SF-12 mental component was .36 ($p < .001$).

[12] According to the Healthy People 2000 review, the proportion of adults reporting adverse health effects from stress, for people age 18 or older without disabilities, was 33.9 percent in 1995 (National Center for Health Statistics, 1999).

[13] The direct stresses of parenting appear not to have contributed to the group differences in feeling stressed. Survey respondents were administered an 11-item Parenting Stress Scale, and there were no significant group differences in scores on this scale.

[14] The term "depression" was volunteered in the ethnographic interviews; that is, there were no direct questions or probes. In the second round of ethnographic interviews, respondents were administered the CES-D, which will yield information about their risk of depression for future analysis.

> *I suffer a lot from depression. I close myself up in the room and start crying. When I see myself without money, without anything, that my kids are asking for this and for that, I get nervous.* Amarilis, Miami

This last woman had suffered through periods of depression so severe that she had worried at one point that her children might be taken away from her as a result.

Stress was also an important theme in the ethnographic interviews. Many women mentioned stress as being a constant part of their lives:

> *Emotionally, sometimes I get, how should I say, depressed. There's like this and that, that you have to get a job, that you have to pay the rent. So, you start building up, like stress.* Adela, Miami

> [Interviewer:] *I remember that you mentioned you . . . can get sort of stressed at times, does that happen often or how often?*
> [Respondent:] *Well most every day. Seriously, almost every day.* Heather, Cleveland

> *Oh, I'm stressed out. See, I'm nice and calm now, talking to you, but there's times I am so stressed out. I just, I pop a fuse and I'll flip a chair and the kids just back away from me, "Okay." In fact, I broke my coffee table the other day doing that.* Olivia, Cleveland

> *Well, with me I think stress in the beginning of the year I might have been a little stress, a little depression but I kind of snap out of it . . . but I might be under stress. I am probably under stress and don't know it. I did lose my hair in the back and so I guess that was a sign that I was under stress and didn't know it and some days I just want to lie in the bed and don't want to be bothered and I just make myself get up and go.* Pam, Philadelphia

> *See my nerves are bad, right but I have a lot of patience and when the day comes I am tired but I can't sleep because I know it is things on my agenda that I have to do and they need to be done and I need rest. . . It is terrible feeling, it is so frustrating, days in and days out and finally my eyes just say enough is enough and now it is coming down on me. I am tired now because I have not slept all night.* Shaneeda, Philadelphia

Some respondents mentioned the stress of trying to make ends meet or of just being on welfare:

> *I mean it's, it's not easy living on welfare. . . . But, you get all this extra stress from trying to make ends meet.* Melissa, Cleveland

> *Oh yeah, oh yeah. Worry about you know, everything in general. The health and welfare of the kids. Their mental health. You know, making sure there's enough food in the house, the bills are paid, and they have what they need and more.* Wendy, Cleveland

> *I am now depressed and my children are worried about how they will survive if the benefit is cut.* Da, Los Angeles

> *Imagine, these days I am uncontrolled. The emotional part is out of control these days. . . . I am very troubled for not being able to pay my debts.* Mariela, Miami

Other respondents reported that welfare reform and the new rules and requirements contributed to their stress:

> *Disadvantage of welfare is having that stress and pressure of hey, find a job or your 36 months is up and you're going to be out on the street.* Linda, Cleveland

About job hunting, this same respondent stated:

> *So it's really topsy-turvy. And most things that are available, it's minimum wage. And looking in the newspaper is almost a joke. You can send your résumé to a hundred different people and you're lucky if you get one [response]. So as far as affecting my life, I think it's just put a lot of stress and pressure.*

Thus, many women in the sample were facing a myriad of stressful challenges. Trying to make ends meet was stressful in and of itself, and they were also confronted with the possibility that they might not be able to rely on welfare in the future. Moreover, as discussed in Chapter 3, most of these women faced substantial material hardships, which also contribute to stress.

In summary, the women in the Urban Change sample were at higher-than-average risk of depression and mental health problems. Women who worked, especially those who had left welfare, were less at risk than those who did not, but even they had greater emotional difficulties than national samples of adults.

III. Substance Use

Among the many "myths" about welfare mothers is the common characterization that many of them are drug addicts or alcoholics. There is evidence that welfare recipients' rates of using alcohol are similar to rates for the general population but that drug use rates are, in fact, somewhat higher. According to a study based on the 1992 National Longitudinal Alcohol Epidemiological Survey (NLAES), among women who were AFDC recipients at the time of the survey, 12.0 percent were heavy drinkers (defined as an average daily consumption of more than two drinks or as consumption of five drinks or more on at least 12 occasions during the previous year). In contrast, 14.8 percent of the U.S. population *not* receiving welfare benefits were heavy drinkers. Among the welfare recipients, heavy drinking was less prevalent among African-Americans (10.2 percent) than among whites (15.0 percent). With respect to use of any nonprescription drug, the rate was 9.7 percent for female AFDC recipients, compared with 5.1 percent among all nonwelfare recipients. Drug abuse/dependency (defined through complex criteria)[15] was also somewhat higher among AFDC mothers (3.3 percent) than nonwelfare recipients (1.5 percent). Drug use among welfare recipients, like heavy drinking, was more common among whites than African-Americans (Grant and Dawson, 1996). Regardless of the rates for welfare recipients in comparison with others, it seems likely that drug and alcohol problems for the minority who are affected pose special challenges in a time-limited welfare environment.

---

[15] Any drug use was defined as taking of any of the following medicines or drugs "on your own" (that is, without a prescription) at least 12 times during the previous year: sedatives, tranquilizers, opioids, amphetamines, cannabis (including hashish), methadone, heroin, or other drugs such as hallucinogens, inhalants, or solvents. Respondents classified as abusers were required to meet at least one of the following criteria: continued use despite social or interpersonal problems, hazardous use, legal problems, and neglect of role obligations. A diagnosis of dependence (continued)

Substance Use: Highlights of the Findings

- Most women in the Urban Change study reported that they had not gotten drunk from alcohol and had not used any drugs in the month before the interview.
- There were no work/welfare group differences with respect to frequency of getting drunk.
- Former recipients who were working were the least likely of any group to report drug use in the month before the interview.
- Ethnographic data suggest that the women have been affected by substance use, either by having family members who have used or by living in neighborhoods affected by drugs.

Women in the Urban Change survey sample were asked to report the frequency of having had enough alcohol to get drunk in the past month and of using various drugs in the past month.[16] As seen in Table 5.2, slightly more than one-fifth of the survey respondents reported being drunk one or two times in the past month, and nearly 7 percent reported being drunk three times or more.[17] There were no significant differences across the four work/welfare groups with respect to frequency of having gotten drunk.

With respect to drug use, a minority of respondents (about 10 percent) reported using any type of drug in the prior month, which is similar to the rate reported by AFDC recipients in the 1992 NLAES (Grant and Dawson, 1996); 8.7 percent reported using marijuana, and 2.5 percent

---

required affirmative responses to three or more of the following seven criteria: tolerance; withdrawal; unsuccessful attempts or persistent desire to stop use; use for longer or in larger amounts than intended; activities given up in favor of use; time spent obtaining, using, or recovering from substance effects; and continued use despite physical or psychological problems.

[16] It is possible that both types of behaviors were underreported because of social-desirability factors.

[17] The survey asked respondents about the frequency of having gotten *drunk* from alcohol in the past month, rather than the frequency of any alcohol consumption or the quantities of alcohol consumed. Unfortunately, this makes comparisons with other samples difficult. However, it might be noted that in a national sample of females age 18-25 in 1997, 17 percent reported five drinks or more on the same occasion at least once in the past month (National Center for Health Statistics, 1999, Table 64). In a study of welfare recipients in Alameda County, 21 percent of the sample reported weekly alcohol use, and 10 percent reported binge drinking (Speiglman et al., 1999).

The Project on Devolution and Urban Change

Table 5.2

Self-Reported Substance Use in Past Month, by Work and Welfare Status[a]

Substance Use (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Drunk from alcohol					
Never	72.0	71.7	71.5	72.0	73.9
1-2 times	21.0	21.9	21.4	21.3	16.6
3 or more times	7.0	6.4	7.1	6.7	9.4
Drug use					
No drug use	90.8 ***	93.4	90.0	89.2	89.9
Marijuana	8.7 ***	6.5	10.0	10.3	8.3
Heroin, cocaine, or crack	2.5 ***	0.8	2.2	3.0	5.3
No alcohol or substance use	69.6	70.0	69.0	69.0	71.8
Sample size	3,602	1,200	603	1,396	403

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

reported using hard drugs such as heroin, cocaine, or crack.[18] There were significant group differences in drug use (even after controlling for demographic characteristics) across the four work/welfare groups. Working welfare leavers reported the lowest use of marijuana (6.5 percent) or hard drugs (0.8 percent) of any group. Nearly seven times as many welfare leavers who were not working reported using hard drugs as leavers who did work (5.3 percent versus 0.8 percent, respectively). Furthermore, the proportion of women reporting hard-drug use in the no-work, no-welfare group was nearly twice the size as in the next-largest group, the nonworking current recipients (5.3 percent versus 3.0 percent, respectively).

The majority of the women in the survey sample (nearly 70 percent) reported having neither gotten drunk from alcohol nor using any drugs in the month prior to the interview. There were no significant group differences across the four work/welfare groups for this outcome.

Although women in the ethnographic sample were not specifically asked to discuss substance abuse problems, some spontaneously discussed them during the course of the interview.[19] Several mentioned drug use in the past:

> *And I would spend all the money up on, crack. There were days. There were days years ago. Yeah. But recently in the last 12 months, no.* Jannelle, Cleveland

> *I used to be a drug addict. I was using, you know, cocaine. But, I beat my problem and I'm back to reality, and that's all I can do for my children.* Anna, Philadelphia

> *But I used to do drugs, like cocaine and stuff. But now, man, that sucks. . . . I cut myself off from that.* Smith, Los Angeles

> [Regarding drug use:] *No. Before yes, occasionally, but not now.* Amarilis, Miami

A number of women discussed how their lives had been affected by the substance abuse and alcohol problems of others.[20] The next section of this chapter notes the relationship between drugs and alcohol and domestic violence.

IV. Domestic Violence

National surveys have demonstrated that domestic violence is a problem faced by substantial numbers of women in the United States. Estimates from these surveys suggest that about 1.8

---

[18] In 1997, 8 percent of women age 18-25 nationally used marijuana, and 0.5 percent used cocaine in the prior month (National Center for Health Statistics, 1999, Table 64). Among women age 18-25 in the Urban Change survey sample (n = 450), 8 percent reported marijuana use and 0.4 percent reported cocaine use in the prior month — that is, virtually identical to national rates of same-age young women.

[19] However, the ethnographic respondents were asked to provide information on expenditures in the prior month. Among women in Cleveland, only 16.7 percent reported expenditures on alcohol. The range was from $0.00 to $43.30, and the average was $2.49 per household. As ethnographic interviewers build rapport with these women in subsequent rounds, the women may be more forthcoming with such sensitive information as substance abuse.

[20] Women in the survey sample were asked whether someone in their household had a problem with drugs or alcohol in the prior year; 12.9 percent answered affirmatively.

million women — more than 3 percent of women who live with a husband or partner — are physically abused each year (Plichta, 1996; Straus and Gelles, 1990).

Domestic Violence: Highlights of the Findings

- Over 40 percent of the Urban Change survey sample had experienced physical or emotional abuse in the prior year.
- About one out of ten women had been physically abused in the prior year,
- Former recipients who worked were least likely to have experienced physical and non-physical abuse.
- Although women in the ethnographic sample were not specifically asked about domestic violence, many of them volunteered information about abuses they had experienced.

The health consequences of domestic violence are appreciable. In addition to being at increased risk for physical injury or death, victims of domestic violence are also at risk for complications of pregnancy and childbirth, gynecologic problems, sexually transmitted diseases, chronic somatic disorder, and a number of mental health problems (such as depression, anxiety disorders, suicide, alcoholism, and substance abuse) (see, for example, McCauley et al., 1998; Stark and Flitcraft, 1996; Eisenstat and Bancroft, 1999; McFarlane, Parker, Soeken, and Bullock, 1992; Roberts, Williams, Lawrence, and Raphael, 1998). The cost of direct medical and mental health care to domestic violence victims was estimated in 1995 to be about $1.8 billion per year (Miller, Cohen, and Wierseman, 1995).

Although domestic violence occurs at all socioeconomic levels, poor women are at especially high risk. Lloyd (1996), for example, studied a sample of low-income women in Chicago and found that about 18 percent had experienced physical aggression by a male partner in the previous 12 months. Low-income men — especially those who abuse alcohol or drugs — have been found to be disproportionately likely to be the perpetrators of physical assault (Kyriacou et al., 1999). Not surprisingly, then, studies have indicated that domestic violence affects a high percentage of women on welfare. Several researchers have found a lifetime prevalence rate of about 50 percent to 75 percent among recipients and a prior-year physical abuse rate of 15 percent to 20 percent (Bassuk et al., 1996; Colten, Cosenza, and Allard, 1996; Raphael and Tolman, 1997; Barusch, Taylor, and Derr, 1999, Danzinger et al., 2000).[21]

---

[21] In recognition of the fact that welfare recipients who are domestic violence victims face difficulties fulfilling the strict participation requirements established under PRWORA, Congress adopted the Wellstone-Murray amendment as part of the new welfare law, which gives states the option to waive work requirements and time limits for victims of domestic violence.

Existing evidence suggests that women on welfare who are in abusive relationships encounter interference from their partners as they attempt to progress from welfare to work. For example, Colten et al. (1996) found that abused women in their sample of welfare recipients were about 15 times more likely than never-abused recipients to have a current or former partner who would not like her to go to work. Moore and Selkowe (1999), based on data from Wisconsin welfare recipients who were domestic violence victims, reported that abusive partners undermined the women's efforts to work or participate in work activities in a variety of ways, such as causing disturbances at the workplace, calling the women repeatedly at work, refusing at the last minute to provide child care or transportation, or threatening to harm (or actually harming) the women to prevent them from working. It was therefore expected that rates of domestic violence would be lower among women in the Urban Change sample who were working than among those who were not.

In the survey, women were asked to indicate whether, in the previous year, they had experienced four different types of abuse: verbal or emotional abuse ("Did someone yell at you all the time or put you down on purpose?"); psychological control ("Did someone try to control your every move?"); threats ("Did someone threaten you with physical harm?"); and physical abuse ("Did someone hit, slap, kick, or otherwise physically harm you?"). Women who answered affirmatively were asked to indicate who had done these things to them most recently.

Consistent with previous research that has shown high rates of domestic violence among former and current welfare recipients, the data indicate that over 40 percent of the Urban Change survey sample had experienced at least one form of abuse in the prior year. As shown in Table 5.3, verbal abuse was the most prevalent, reported by about one-third (32.0 percent) of the sample, followed closely by reported attempts to control their lives (26.5 percent). More than one out of ten women had been threatened with physical harm in the previous 12 months (11.4 percent), and nearly as many had actually been hit, slapped, or otherwise physically assaulted (8.8 percent).[22] In each case, the most recent perpetrator was most likely to be a current or a former partner. For example, among the women who had been physically abused, 27.4 percent said a current partner had done it, and 36.6 percent said a *former* partner or husband had abused her (not shown in tables). Other physical abusers included the women's fathers (5.7 percent), their own children (5.4 percent), or other male relatives (5.5 percent).

As shown in Table 5.3, there were significant differences among the four work/welfare groups in their experience with domestic violence. For each type of abuse, former recipients who were working were least likely to have experienced it in the previous year. The other three groups of women were fairly similar in their domestic violence experiences in the preceding year, except that women who worked and also received welfare had a lower rate of physical abuse than the two nonworking groups, but they had a higher rate of having had efforts to control them. There were no noteworthy group differences regarding the perpetrator of the abuse (not shown).

---

[22] This rate is substantially lower than the 15 to 20 percent reported in other studies of welfare recipients. The reason for this disparity is not known.

The Project on Devolution and Urban Change

Table 5.3

Domestic Violence in Past Year, by Work and Welfare Status[a]

Outcome (%)	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Type of abuse to respondent						
Verbally abused	32.0	***	26.6	33.8	35.9	31.7
Every move controlled	26.5	***	22.1	22.2	27.0	28.9
Threatened with physical harm	11.4	***	8.6	12.4	13.5	11.0
Physically abused[b]	8.8	***	6.6	7.6	10.4	11.1
Number of abuse events						
None	59.2	***	64.1	55.8	56.3	59.7
1-2	31.5		29.4	34.1	32.8	29.2
3-4	9.4	***	6.5	10.2	10.9	11.1
Sample size	3,618		1,206	606	1,396	410

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] The respondent reported that she was hit, slapped, or kicked.

Working former recipients were most likely to have avoided *all* types of abuse in the previous year, and they were especially unlikely to have been the victim of three or four different types of abuse. Again, the other three groups had similar patterns of abuse: About a third of the women in each group had had one or two types of abuse, and about 10 percent had had three or four types.

In the baseline round of interviews with the ethnographic sample, there were no specific questions regarding domestic violence. Nevertheless, many women *spontaneously* discussed having been physically or psychologically abused at some point in their adult lives — in virtually all cases, by a partner or husband (although none admitted that they were currently in an abusive relationship).[23] A number of women also volunteered that they had been physically abused as a child, typically, by a father or stepfather.

Women's experiences with domestic violence ranged from a single episode by a partner whom they had left immediately after the occurrence to a longer history of abuse by one or multiple partners. Here is how one woman from Cleveland described the abusive situation and its effect on her well-being:

> *He used to beat me. I just went through a lot of traumatic experience between '96 and '97. He used to beat me for little dumb things, you know. He thought I was having sex with other people, and did it with different guys, and it was always nothing like that. . . . I mean, I really understand how these women feel about, they said they're scared, they don't know how to get out. But once you fall into that domestic violence, you really don't know where to turn, who to turn to. . . . I'm still healing today.* Glenda, Cleveland

Several respondents indicated that the abusiveness stemmed from the fact that their partners were violent, hot-tempered, or controlling:

> *We ran into a lot of arguments because as he got older he needed someone younger. Then I went through the beating stage. I was pregnant with my daughter. He's the kind of person with a short temper fuse and I could never figure him out. I was pregnant with her. I was eight months and he tried to push me out a second-floor window.* Eileen, Philadelphia

> *We just kind of drifted apart emotionally, physically, and then he was, uh, his temper became increasingly bad so I divorced him. He was physically violent with me just a few times. Not bad, but he had struck me a few times.* Kathy, Cleveland

> *I lived a life of abuse. . . . His problem was a machismo thing . . . he thought he was in authority and you had to obey him. . . . He improved himself. He was even learning English, but I wasn't allowed to do the same. He always forbade me to study.* Juliana, Miami

---

[23] Because so many women described domestic violence problems in the baseline interviews, explicit questions were added to the interview protocol for the second round of ethnographic interviews.

Consistent with prior research, however, many of the abused women implicated drugs or alcohol as powerful contributors to their partners' behavior. For example, one woman in Philadelphia had cancer, and her partner was her caretaker; although he demonstrated considerable concern about her health, he was also abusive when he used drugs:

> *That was weird; he was really concerned about getting my treatment and my getting better. That's why I can't understand why he hit me. When he was high, that's when he would do it, and he would not* remember at all. Danielle, Philadelphia

Several women indicated that they had lived in fear for their personal safety and for the safety of their children — some of whom were also subjected to physical or emotional abuse by their mothers' partners. Here is how two women described their situation:

> *He started his drinking again, he started being abusive, then he started smoking weed and combining that with alcohol. He would spend everything on the alcohol and drugs. I mean, we would barely have food in the house. [He was] physically abusive to [my daughter], and mentally to me. He was starting to get abusive with me. I would wake up in the middle of the night and he would be choking me. I would wake up and he would be having intercourse with me while I was sleeping. The last six months of the marriage I slept with a loaded gun at my fingers.* Wendy, Cleveland

> *As my kids hit a certain age, I had to watch out for them because he had a tendency to become slap-happy with them. I tried to get stay-away orders, court orders. . . . I had gotten my apartment. Every time he found out where I lived at in the apartment, he had came like all hours of the night, demanding that he had a right to see his children. He broke my doors down. He came, like, two o'clock in the morning. And one night he had come up and he had a whole bunch of girls downstairs and they had beat me up. Here I was three months pregnant, and I lost my baby.* Eileen, Philadelphia

As might be expected, the women's battering resulted in both emotional and physical harm. Several women spoke of having been beaten so badly they had required hospitalization:

> *He beat me down with a stick. . . . When I was getting back in the car, this big stick just hit me upside my head and he kept hitting me and hitting me. I got, like, a dent in the back of my head and I had to go to the hospital.* Mary, Philadelphia

The women also expressed deep concerns about raising their children in violent and abusive environments. In addition to worrying about or witnessing the children being physically hurt, they were afraid that the children's exposure to their own battering would be traumatic and damaging. Some also worried about the possibility that their children — especially sons — would become abusive, either because they would learn disrespect for women by seeing their mothers treated badly or because of "bad genes":

> *It wasn't a happy period, it sort of depressed me that I was pregnant with this man's children. And, you know, I used to get beat on. I'd say it depressed me because, I'm like, dang, I got to have something related to him in my life for the rest*

> *of my life. It's got his blood in it. . . . So, I always wonder how my kids will turn out because they are related to him.* Glenda, Cleveland

Although most of the women in the ethnographic sample who spontaneously discussed domestic violence spoke primarily of physical abuse, many also told the interviewer about emotional abuse and intimidation. One theme that emerged was the mothers' fear — sometimes because of explicit threats — that the fathers would take their children away from them:

> *He got a mouth on him, and he really knows how to make me, not scared of him, but I think about my son more like, how do I know he is not going to just pick him up and leave. That is what scares me.* Sarah, Philadelphia

> *The only way I am frightened of him, I am afraid some day he is going to try to come and take her. He threatens that a lot, and he can always run to Puerto Rico and take her and I will never see her again.* Celena, Philadelphia

In summary, a substantial number of women in the ethnographic sample had volunteered to speak about their harrowing experiences with domestic violence. Although no one acknowledged that she was being physically abused at the time of the interview, many of the abused women made it clear that the abuse was not far behind them and that the emotional wounds persisted.

V. Mental Health in Relation to Material Hardship and Physical Health

Mental Health and Material Hardship/Physical Health: Highlights of the Findings

- Women who were experiencing material hardships such as food insecurity, housing problems, and homelessness were at especially high risk of depression.
- Women at high risk of depression were more likely than others to smoke, to be in fair or poor health, and to have unfavorable scores on the physical component of the SF-12.
- Substance use increased as the risk of depression increased.
- Women at high risk of depression were especially likely to have been physically abused in the past year.

Table 5.4 presents selected material hardship and health outcomes, by risk of depression, as measured by the CES-D. In general, women who were at high risk of depression also had more material hardships, poorer health, and worse mental health outcomes than women not at risk.

The Project on Devolution and Urban Change

Table 5.4

Selected Material Hardship and Health Outcomes, by Risk of Depression[a]

	Risk of Depression[a]		
Outcome (%)	Low	Moderate	High
Food insecure, past 12 months[b]	37.8 ***	55.8	63.8
Has worst-case housing needs[c]	32.1 ***	33.0	41.0
Lived in emergency shelter or was homeless in prior year	1.4 ***	1.8	4.9
Has 3 or more material hardships[d]	19.9 ***	30.9	41.9
Obese[e]	64.6	69.0	66.6
Currently smokes cigarettes	34.6 ***	42.6	47.2
Reports fair to poor health	15.2 ***	22.8	47.0
Scored less than 40 on physical component of SF-12[f]	15.1 ***	26.4	38.7
Self-reported substance use, past month			
Drunk 3 or more times	4.7 ***	7.3	10.9
Any drug	6.2 ***	10.6	15.4
Heroin, cocaine, or crack	0.9 ***	2.5	5.3
Physically abused, past 12 months[g]	4.4 ***	7.6	17.7
Sample size	1,817	820	987

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

[b] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

Table 5.4 (continued)

[c] Families have worst-case housing needs if they have no rental assistance and pay more than 50 percent of their income (not including food stamps) for rent and utilities.

[d] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[e] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

[f] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[g] The respondent reported that she was hit, slapped, or kicked.

In terms of material hardships, there was a significant relationship between food insecurity and risk of depression. Nearly two-thirds of the women who were at high risk of depression were food insecure, compared with 37.8 percent of those at low risk of depression. Housing hardship is another potential contributor to chronic stress and depression. As described in Chapter 3, those with unsubsidized housing expenditures totaling more than 50 percent of their total income (not including food stamps) in the prior month were considered to have worst-case housing. Over 40 percent of those at high risk of depression had worst-case housing needs, compared with about one-third of those at moderate or low risk. A similar pattern was observed with respect to having lived in an emergency shelter or being homeless in the prior year. Finally, using the index that measured the number of material hardships out of eight considered (see Chapter 3 and note d in Table 5.4), more than twice as many women at high risk of depression (41.9 percent) as women at low risk (19.9 percent) had three material hardships or more. Looking at material hardship indicators and risk of depression the other way (that is, What percentage with a given hardship were at risk?), 61.0 percent of the women who were food insecure and 71.1 percent of those who experienced hunger were at moderate or high risk of depression, compared with 38.6 percent of the women who were food secure (not shown in table). Women who had been homeless (70.8 percent) and who had three or more material hardships (65.0 percent) were also especially likely to be at risk of depression (not shown).

In terms of physical health, there was no relationship between obesity and depression. However, there were significant differences in smoking patterns: Almost half (47.2 percent) of those who were at high risk of depression were smokers, which is more than 12 percentage points greater than those at low risk of depression.[24]

A relationship between self-reported health status and risk of depression was also observed in this sample. More than three times as many respondents at high risk of depression (47.0 percent) as those at low risk (15.2 percent) reported fair or poor health. This same pattern was also found for those scoring less than 40 on the physical component of the SF-12.

The relationship between substance use and risk of depression was also examined. For all three outcomes related to substance use in the prior month (becoming drunk three times or more, any drug use, and use of heroin or cocaine), the patterns were similar: As the risk of depression increased, the proportion using substances increased. For example, 15.4 percent of the women at high risk of depression reported any drug use in the past month, compared with 10.6 percent at moderate risk and 6.2 percent at low risk.

Finally, domestic violence was also found to be strongly related to depression risk. About 18 percent of the respondents at high risk of depression reported being physically abused in the year prior to the interview. This was four times the proportion at low risk of depression (4.4 percent). And, looked at the other way, 74.8 percent of the women who had been physically abused were at risk of depression, compared with 47.2 percent among those who did not report physical abuse (not shown in table).

---

[24] In the present study, it would be impossible to determine whether smoking was a determinant of depression or vice versa. However, a recent study found that depression contributed to smoking on a daily basis, though the data did not support the theory that depression led to the initiation of smoking (Breslau et al., 1998).

VI. Discussion

This population of women living in high-poverty neighborhoods was at great risk of poor mental health outcomes, as evidenced by the measures of mental health status included in the survey. Consistent with the literature, women who were working fared better on measures of mental health than nonworking women did. This finding must be interpreted cautiously, given the cross-sectional nature of the data. It is possible that working provided some mental health benefits (for example, heightened self-esteem), but it is also probable that women with fewer emotional problems were better equipped to enter or succeed in the labor market.[25] In either case, special attention must be paid to the mental health issues faced by such women as welfare reform regulations require increasing participation in work activities and, when the time limits hit, termination of benefits for most recipients.

While substance use was apparently not an issue for the majority of women in this study, the possibility of underreporting because of social stigma cannot be discounted; actual levels of substance use could be higher than reported. And although only a minority of the women appear to have been affected, those with such problems will need assistance in terms of both their ability to comply with program requirements and their ability to find or keep a job.

Domestic violence played a role in the lives of many of these women. About 40 percent of the sample reported experiencing some type of abuse in the past year, and about 9 percent had actually been physically harmed during the same time period. Working welfare leavers, relative to women in the other three work/welfare groups, were most likely to have avoided *all* types of abuse in the previous year. This is consistent with research that has documented the difficulties that abuse victims face in finding and keeping a job.

Finally, as evidenced by the relationship between being at high risk of depression, on the one hand, and having negative material hardship and physical health outcomes, on the other, many of these women must also contend with co-occurring problems (this issue of multiple barriers will be discussed in Chapter 8). Taken together, this evidence suggests that women who live in areas of high poverty may have potentially serious mental health issues that should be addressed. This is particularly relevant as more and more women are expected to move off of welfare and into paid employment. Particular attention needs to be paid to those women who may face employment barriers such as depression, substance use, and domestic violence.

---

[25] A few ethnographic respondents who had begun to work specifically mentioned the beneficial effects that work had on their mental health. For example, one woman in Miami said that she felt mentally more stable and calmer since finding a job. However, there is also evidence in the ethnographic interviews that emotional problems interfered with work. Another woman in Miami, who suffered from chronic depression, described how she had had to leave her job early one night because she had an attack of crying; she subsequently lost that job.

Chapter 6

Access to Health Care and Health Services Utilization

I. Introduction

Access to health care and utilization of health services are particularly important for people with existing health problems (that is, needs for health care) and with risks for health problems. As discussed in Chapters 3, 4, and 5 of this report, women in the Urban Change survey and ethnographic samples — even former recipients who were working at the time of the survey — were disadvantaged relative to the U.S. population with respect food insecurity, housing problems, material hardships, and physical and mental health. These results are consistent with the literature on the effects of poverty and low socioeconomic status on health and well-being, and they indicate that there is substantial demand for health services in this population.

Having health insurance and a usual source of care are two commonly used indicators of access to health care. According to the behavioral model of health services use originally developed by Andersen (1968) and refined over several decades (see Andersen, 1995), having health insurance and a usual source of care are "enabling factors" that facilitate the use of needed health care services. Both factors enable entry into the medical care system when acute or ongoing care is needed — the former by providing financial access, and the latter by promoting familiarity, convenience, confidence, and satisfaction (Bloom, Simpson, Cohen, and Parsons, 1997). In the absence of health insurance coverage, access to health care is restricted to what can be paid out of pocket and to reliance on emergency rooms and free clinics that provide care to the indigent.

Health insurance coverage, the primary determinant of access to health care in the United States, is neither universal nor evenly distributed in the population. It is estimated that 44.3 million people in the United States were uninsured in 1998 (Campbell, 1999; Pear, 1999), while many more were underinsured.[1] The percentage of the U.S. population who were uninsured at some point in the prior month was estimated to have increased from 12.9 percent in 1987 to 15.6 percent in 1996 (Pamuk et al., 1998). Data from the 1996-1997 Community Tracking Study indicate that the percentage uninsured in the prior month had risen to 17.0 percent (Center for Studying Health System Change, 1998).[2]

---

[1] Persons who are underinsured have health insurance but lack coverage for specific health problems. Lack of coverage may result because of an excluded preexisting condition or because a specific health plan does not cover or only part covers some aspect of care.

[2] Estimates of the percentage uninsured and insured by a particular means can be obtained from a variety of sources, such as the Current Population Survey, the National Health Interview Survey, the Medical Expenditure Panel Survey, and the Community Tracking Study. Due to numerous methodologic differences (for example, the way insurance is defined, how uninsurance is measured, the length of time a person must be uninsured to be counted as uninsured, how the population is defined), estimates of the percentage uninsured or with a particular type of insurance vary across sources (for detailed discussions of these issues, see Center for Studying Health System Change, 1998; Pamuk et al.,1998; U.S. Department of Health and Human Services, 1998). Despite these differences, recent increases in uninsurance have been consistently observed and reported. In this chapter, insurance coverage estimates are compared primarily with estimates derived from the Community Tracking Study (Center for Studying Health

(continued)

Lack of insurance has consistently been shown to be more prevalent among young adults age 18-39, the poor, and blacks and Hispanics than among older adults, the nonpoor, and whites, respectively (Carrasquillo, Himmelstein, Woolhandler, and Bor 1999). Additionally, the percentage uninsured has been shown to vary substantially by state and region (Pamuk et al., 1998). Among low-income women, health insurance coverage is strongly associated with work/welfare status because of the strong link between receipt of cash assistance and Medicaid eligibility, the fact that low-wage and part-time jobs generally do not offer health insurance benefits, and the fact that many low-income working women and families are unable to afford employer-sponsored or market-based private health insurance (Families USA Foundation, 1999, 2000; Meyer and Pavalko, 1996; O'Brien and Feder, 1999; Seccombe and Amey, 1995).

There is substantial evidence that people who are insured are more likely than uninsured people to have a usual source of care other than the emergency room (Bloom, Simpson, Cohen, and Parson, 1997).[3] Having health insurance and a usual source of care are generally among the strongest predictors of health services utilization, and they have been shown consistently to enhance timely use of medically necessary health services, increase use of preventive health care, increase continuity of care for chronic conditions, and reduce costly emergency room utilization (Centers for Disease Control, 1995; Millman, 1993; Schoen et al., 1997). By increasing access to and utilization of medically necessary care, health insurance and having a usual source of care reduce unmet need for health care (that is, medically necessary care that is not obtained). Unmet need for health care is a particularly important health outcome because it measures the extent to which people who are at risk or ill forgo beneficial preventive, curative, and ameliorative health care services, and because it gauges the extent to which access to needed health care is realized in the population (Aday and Andersen, 1974; Andersen and Aday, 1978).

In this chapter, data from the Urban Change survey and ethnographic samples are used to examine access to health care and health services utilization in relation to women's work/welfare status. In addition, supplemental analyses examine the extent to which observed differences in having a usual source of care, utilization of health care services, and unmet need for health care can be accounted for by group differences in need for health care (that is, health problems) and health insurance coverage.

II. Respondent's Access to Health Care

Obtaining adequate access to health care is a persistent problem for millions of Americans, especially the working poor, who often lack both health insurance coverage and the ability to pay for care out of pocket (Families USA Foundation, 1999, 2000; Meyer and Pavalko, 1996;

System Change, 1998), which, like the Urban Change survey and unlike the other sources noted above, measured insurance coverage at the time of the interview.

[3] Generally, insurance status is conceptualized as a determinant of having a usual source of care and of the type of place where care is usually accessed. Among all adults 18-64 years of age, 82.7 percent had a usual source of care. However, only 60.5 percent of those with no health insurance had a usual source of care. Among people who report having a usual source of care, those who are publicly insured and lack health insurance, respectively, are more likely than those with private insurance to report a clinic or the emergency room as their usual source of care, while those with private insurance are more likely to report a private doctor as their usual source of care (Bloom, Simpson, Cohen, and Parsons, 1997).

Seccombe and Amey, 1995). Welfare recipients are generally not among the uninsured because recipients of cash assistance are eligible for Medicaid coverage for themselves and their children. It is well documented that, for some women, a primary motivation for exiting the low-wage labor market, and getting on and staying on welfare, is the health insurance coverage that the receipt of cash assistance makes possible (Davidson and Moscovice, 1989; Moffitt and Slade, 1997).

The fact that the working poor are overrepresented among the uninsured has led both supporters and critics of welfare reform to be concerned that an unintended consequence of welfare reform might be an increase in the percentage uninsured (Families USA Foundation, 1999; Ku and Bruen, 1999; Ku and Garrett, 2000; Larkin, 1999). Despite the new provisions created by PRWORA that aim to mitigate potential loss of health insurance associated with moving from welfare to work,[4] findings from recent studies of welfare leavers and evidence of substantial declines in Medicaid caseloads since 1996 suggest that this concern about increasing uninsurance is warranted (Coulton et al., 2000; Ellwood and Ku, 1998; Families USA Foundation, 1999, 2000; Garrett and Holohan, 1998; Ku and Bruen, 1999; Moffitt and Slade, 1997).[5] One recent assessment of the impact of macroeconomic factors and state welfare policy changes on Medicaid participation suggests that welfare reform policy changes have been responsible for some decreased Medicaid coverage (Ku and Garrett, 2000). This study found that macroeconomic factors and welfare policies contributed about equally to declines in the cash-related Medicaid caseload in 1996, but that increases in noncash Medicaid participation were not enough to offset the declines resulting from declining cash assistance caseloads.[6] Another recent study concluded: "It is now generally accepted that welfare reform has contributed to the growth in the number of Americans without health insurance" (Families USA Foundation, 2000, p. 1).[7]

---

[4] As discussed in Chapter 1, PRWORA expanded Medicaid eligibility by (1) allowing women who leave welfare for work to retain transitional Medicaid benefits for 6-12 months (or longer, at states' discretion) and (2) mandating states to provide Medicaid to families who are ineligible for current cash assistance but who meet the income and family structure guidelines that prevailed for their state's AFDC program on July 16, 1996. Additionally, health insurance coverage for children was expanded through the implementation of the Children's Health Insurance Program (CHIP).

[5] For example, one recent study of welfare leavers in Cuyahoga County documented that most of the families who left cash assistance in the fourth quarter of 1998 (Q4 1998) and the first quarter of 1999 (Q1 1999) remained eligible for noncash Medicaid benefits (Coulton et al., 2000). However, only 51 percent of leavers in Q4 1998 retained Medicaid for themselves, and 57 percent retained Medicaid for their children (56 and 63 percent, respectively, for leavers in Q1 1999). The majority (58 percent) of those who had worked were not offered employer-provided benefits; only 36 percent were offered any kind of health insurance plan. Six months after leaving cash assistance, 59 percent of adults and 69 percent of their children continued to be covered by Medicaid, 17 percent of the adults and 15 percent of their children had private health insurance, and 24 percent of the adults and 16 percent of their children were uninsured.

[6] There was considerable state variation in declines in cash-related Medicaid caseloads and countervailing increases in noncash Medicaid caseloads between 1995 and 1997 in the four states involved in the Urban Change study. In Florida, the AFDC/TANF caseload declined 27.4 percent, while the cash-related Medicaid caseload declined by 24.3 percent and the noncash Medicaid caseload increased by 10.7 percent. In contrast to Florida, the cash-related Medicaid caseload declined more than the AFDC/TANF caseload in California, Ohio, and Pennsylvania. In Ohio and Pennsylvania, the increases in noncash Medicaid were not enough to offset these declines (which is similar to Florida's experience); however, in California, the increase in noncash Medicaid surpassed the decline in cash-related Medicaid. The AFDC/TANF caseload, the cash-related Medicaid caseload, and the noncash Medicaid caseload changes between 1995 and 1997 were, respectively, as follows: California, –.0.3 percent, –12.6 percent, +16.8 percent; Ohio, –19.3 percent, –29.7 percent, and +5.8 percent; and Pennsylvania, –22.8 percent, –27.0 percent, and +21.3 percent (Ku and Bruen, 1999).

Increasing health insurance coverage (and access to health care services) is desirable because it will contribute to individual health and well-being among those with needs for health care, and it is also cost effective to the extent that untreated preventable health problems ultimately result in costly care. The next three sections examine health insurance coverage in the Urban Change survey and ethnographic samples. While these analyses cannot indicate what will happen or has happened with respect to welfare reform, they can document a baseline against which future analyses can be compared.

A. Respondent's Health Insurance Coverage

Respondent's Health Insurance Coverage: Highlights of the Findings

- Overall, 19.5 percent of women in the Urban Change survey sample were uninsured in the month prior to the survey, 30.4 percent had been uninsured at some point in the prior year, and 12.1 percent had been uninsured for the entire year.
- Women who received welfare at the time of the survey (regardless of whether they worked or not) were much less likely than women who had left welfare to have had insurance lapses.
- Women who neither worked nor received welfare at the time of the survey consistently had the worst health insurance outcomes of any of the four work/welfare groups.
- Women in the ethnographic sample clearly understood the advantages that welfare receipt conferred with respect to health insurance. They generally did not think they could get jobs with health insurance benefits, and many women did not know about or adequately understand transitional health insurance benefits. Concerns about losing health insurance appeared to be impeding some women's exit from welfare.

Participants in the Urban Change survey were asked a series of questions about their own and their family members' insurance status in the month prior to the interview. Specifically, women were asked if they or anyone in their household/immediate family were covered by a health insurance plan from a current or past employer or union; a health insurance plan paid for directly by them (that is, a private plan not related to an employer or union); a health insurance plan provided by someone not living in the household; Medicaid, "the government health insurance program for people in need";[8] the state health plan for children;[9] and anything else that was not previously mentioned (for example, Medicare or CHAMPUS). Responses to these questions were used to determine the prior month's health insurance status of the women, their children, and their families and, if they had health insurance, whether they had private insurance or public insurance.[10]

---

[7] State-level analysis of insurance patterns reveals trends in the states represented by the four Urban Change sites. California, Florida, Ohio, and Pennsylvania are among the 15 states with the highest percentage of uninsured, low-income adults. From January 1996 to December 1999 (October 1999 in Ohio), the percentage change in the Medicaid enrollment of parents was –19 percent in California, –37 percent in Florida, –42 percent in Ohio, and –23 percent in Pennsylvania. A three-year average (1996-1998) of estimates of the percentage uninsured among those below 200 percent of the federal poverty level based on data from the Current Population Survey indicates that 45 percent of those below 200 percent of poverty were uninsured in California, 41 percent were uninsured in Florida, 30 percent were uninsured in Ohio, and 28 percent were uninsured in Pennsylvania (Families USA Foundation, 2000).

In addition to inquiring about prior-month insurance coverage, the survey also asked about insurance coverage in the past year. Women were asked to indicate whether there was any time in the prior year when they were personally not covered by any health insurance or health care plan. Those who indicated that they had been uninsured at some point in the prior year were asked to indicate the number of months they had been uninsured.

Table 6.1 presents information on the respondents' insurance status in the prior month and over the course of the prior year. Overall, 19.5 percent of women in the Urban Change survey sample were uninsured in the prior month, which is higher than the 17.0 percent uninsured in the prior month in the U.S. population in 1996-1997 (Center for Studying Health System Change, 1998) (see Figure 6.1). The pattern of differences among work/welfare groups in the percentage of women who were uninsured in the prior month is consistent with expectations: Women who received welfare (regardless of whether they worked or not) were substantially more likely than welfare leavers to have had insurance coverage, even when background characteristics — including income — were controlled statistically.

Consistent with evidence indicating that low-wage workers are worse off than welfare recipients with respect to health insurance, 33.7 percent of working former recipients were uninsured in the month prior to the interview, compared with approximately 6 percent of women who received welfare (regardless of whether they worked or not).[11] Women who neither worked nor received welfare had the highest rate of uninsurance (44.5 percent), which further underscores the extent to which this group of women is materially disadvantaged (see Chapter 3).

---

[8] This question substituted state-specific terms for Medicaid as appropriate (for example, Medi-Cal in California and Medical Assistance in Pennsylvania).

[9] These state plans are called AIM in California, Healthy Kids in Florida, Children's Health Care in Ohio, and the Children's Health Insurance Program in Pennsylvania. Each state health plan was organized under the auspices of the State Children's Health Insurance Program (SCHIP).

[10] Overall, 2.9 percent of Urban Change respondents reported *both* private and public insurance for themselves. In the literature, strategies for categorizing persons with more than one type of health insurance coverage vary. Pamuk et al. (1998) created mutually exclusive categories by assigning respondents to insurance categories on the basis of the following hierarchy: Medicaid, private, other. Thus, a respondent with Medicaid and private insurance was classified as having Medicaid. In contrast, persons with both public and private insurance in the Community Tracking Study (Center for Studying Health System Change, 1998) were classified as having private insurance. Because the methods used to measure insurance coverage in the Urban Change survey were most comparable to those used in the Community Tracking Study, Urban Change respondents who reported use of both private and public insurance were classified as having private insurance.

[11] It is not clear why some women who were receiving welfare at the time of the survey reported that they were uninsured in the month prior to the survey. Those who were currently on welfare are not the same as those who were on welfare in the prior month, but it is unlikely that this alone can account for these results. Another contributing factor may be misreporting of insurance status

The Project on Devolution and Urban Change

Table 6.1

Selected Health Insurance Outcomes, by Work and Welfare Status[a]

Outcome (%)	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Health insurance status, prior month						
Uninsured	19.5	***	33.7	6.1	6.2	44.5
Private insurance[b]	21.2	***	43.3	14.0	8.1	13.2
Public insurance[c]	59.1	***	22.9	79.9	85.7	42.1
Ever uninsured, past 12 months	30.4	***	45.7	15.7	15.6	56.0
Number of months uninsured, past 12 months						
None	72.7	***	57.7	86.3	87.1	49.8
1-6	12.1	***	15.6	8.3	8.2	20.3
7-11	3.1	***	4.5	2.4	1.5	5.7
12	12.1	***	22.2	3.0	3.2	24.2
Sample size	3,737		1,227	624	1,461	425

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

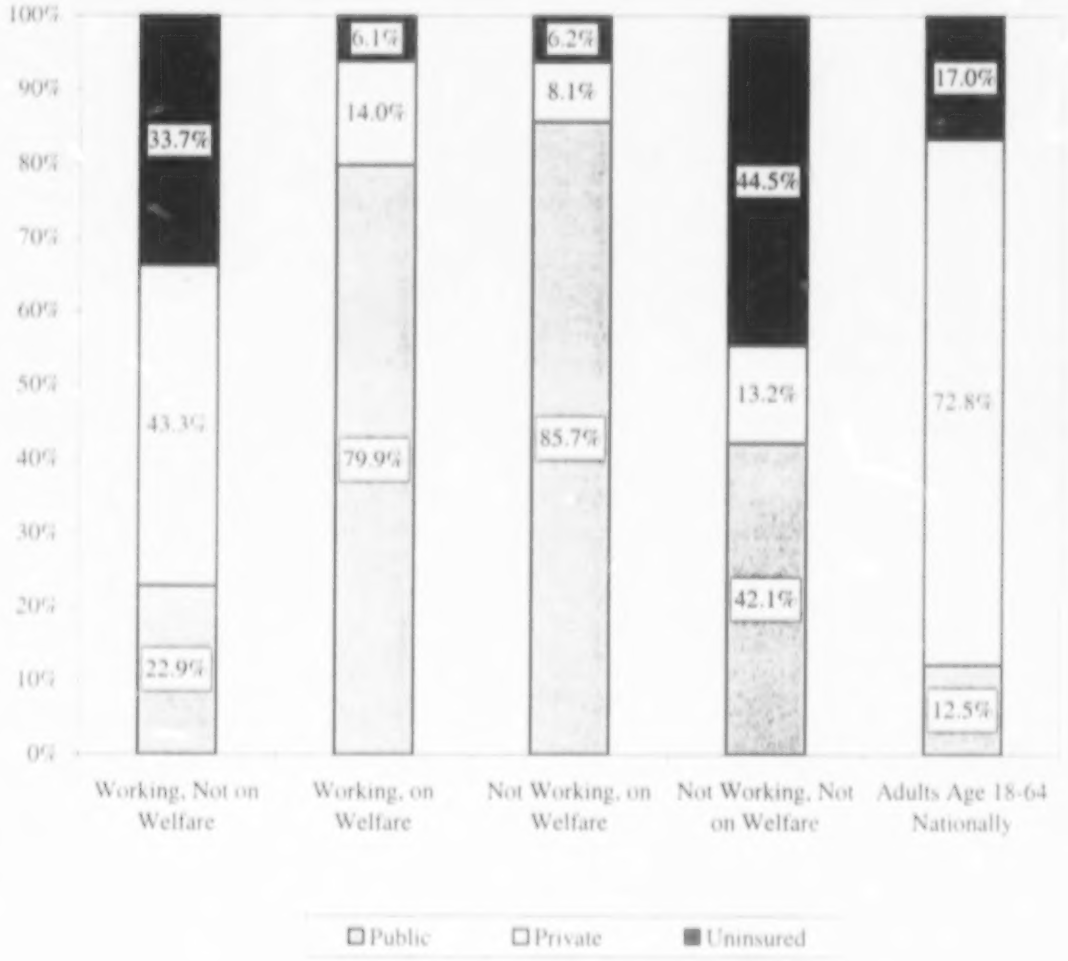
[b] Private insurance includes people who received health insurance from an employer or union, had health insurance that was paid for directly by the respondent or someone in the household or immediate family (that is, private insurance not related to an employer or union), or health insurance that was provided by someone who did not live in the household.

[c] Public insurance includes Medicaid (or the state equivalent), a state health insurance plan, or any other plan not mentioned previously.

The Project on Devolution and Urban Change

Figure 6.1

Health Insurance Coverage in the Prior Month, by Work and Welfare Status[a] and in U.S. Population



SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE: [a]Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

The majority of women in the Urban Change survey sample (59.1 percent) had public insurance in the month prior to the interview, which contrasts sharply with the general U.S. population age 18-64 years old, the majority of whom (72.8 percent) had private health insurance in 1996-1997 (Center for Studying Health System Change, 1998). In the Urban Change Survey sample, approximately 21 percent had private insurance. There were substantial work/welfare group differences in type of insurance, and these remained statistically significant when other factors were controlled. Working welfare leavers were much more likely than women in any of the other three groups to have had private insurance in the month prior to the interview, while welfare recipients (whether working or not) were more likely to have had public insurance.[12] Approximately 43 percent of working welfare leavers had private insurance in the month prior to the interview, compared with 8 percent to 14 percent of women in the other three work/welfare groups.

The vast majority of nonworking current welfare recipients (85.7 percent) and women who combined welfare and work (79.9 percent) had public insurance in the month prior to the interview.[13] While women who neither worked nor received welfare were more likely to have public insurance than private insurance (42.1 percent versus 13.2 percent, respectively), the rate with public insurance among this group was about half that of welfare recipients.

Table 6.1 also presents information on women's insurance status in the prior year: whether they had ever been uninsured and, if so, for how many months they had been uninsured. Not surprisingly, given the longer reference period, a higher percentage of each group were uninsured at *some* point in the year prior to the survey than in the prior month. Overall, 30.4 percent of respondents had had a spell without insurance in the prior year (compared with 19.5 percent in the prior month). Group differences in prior-year insurance lapses were strong, and they followed the same pattern as for being uninsured in the prior month. Women who were on welfare (regardless of whether they worked) had the lowest rate of having been uninsured. Welfare leavers who worked were substantially more likely than welfare recipients to have been uninsured (45.7 percent), but leavers who did not work were the worst off (56.0 percent had been uninsured at some point in the prior year).

A much higher percentage of welfare leavers than current recipients had been uninsured for the entire year prior to the survey. Nearly one-fourth of the leavers, compared with less than 5 percent of the recipients, were uninsured for the entire year.[14] Additionally, women who received welfare at the time of the survey were much more likely to have had health insurance for the entire year prior to the interview than was the case for women who were in the other two groups; about 87 percent of women in the two current-recipient groups had been insured for the entire prior year, compared with only 57.7 percent of women who worked without receiving welfare and 49.8 percent of women who neither worked nor received welfare. Consistent with the patterns observed for the extremes of the distribution (that is, the fully insured and the uninsured), women who received welfare were less likely to have been uninsured for part of the year, both short term (1-6 months) and long term (7-11 months), than were women in the other two groups.[15]

---

[12] It is noteworthy that 22.9 percent of the working former recipients had public insurance in the prior month; this presumably reflects women who left welfare for work and maintained transitional health insurance benefits. As noted in Chapter 2 (see footnote 18), less than half the former recipients knew about transitional Medicaid.

[13] The actual percentage who had public insurance is higher than the figures presented in the text. As discussed in footnote 10, overall, 2.9 percent of women had both public and private insurance. For the purposes of the analyses presented in this report and comparison with other studies, these women were classified as having private insurance.

[14] As noted previously, the fact that some women who were receiving welfare were classified as uninsured likely reflects that some women may have recently come back onto welfare and were uninsured at some point in the prior month and that some women may have misreported their insurance status.

Table 6.2 shows women's health insurance coverage, in the month before the interview, as a function of the recency of their transition off welfare. Among women who left welfare within the prior year, 48.3 percent retained public insurance (presumably transitional or noncash Medicaid). More women became uninsured during this initial transition than became insured privately (30.5 percent versus 21.0 percent). By contrast, women who had left welfare more than one year prior to the interview were more likely to be insured privately (41.0 percent) than to be uninsured (38.6 percent) or to have public insurance (20.2 percent). Thus, rates of insurance increased as time off welfare increased, presumably reflecting the loss of transitional benefits that were initially available to leavers. Still, one out of five women who had exited welfare more than a year earlier was still receiving public health insurance. This suggests that recipients still met the income and other eligibility criteria that applied in their state's AFDC program as of July 1996 (Ku and Bruen, 1999) — or that they misremembered when they had left welfare.

Data from the ethnographic interviews indicate that health insurance concerns were highly salient for women on time-limited welfare. One important theme in the baseline interviews was that concerns about health insurance often shaped women's choices and behaviors. Consistent with the literature (Moffitt and Wolfe, 1992; Wolfe and Hill, 1995), some women indicated that they went on welfare in order to get Medicaid for themselves and their children. For example, when talking about the availability of jobs in her neighborhood, one woman said:

> *There isn't really. Most of them are, like I said, factory work with no benefits. And you can't survive without medical for your kids. That's the only reason I got back on welfare. It's because of the medical. We couldn't afford it.* Melissa, Philadelphia

Another woman, who had a serious, accidental fall that shattered her kneecap, indicated that she went on welfare in part because she thought that Medicaid would help her pay the $14,000 hospital bill:

> *This is the purpose of me getting on welfare — well, not the purpose, but I figure that they'd pay the hospital bill for me.* Sharon, Cleveland

---

[15] Among those who were ever uninsured in the prior year, the average duration of uninsurance in the Urban Change survey sample was 6.4 months (not shown in table). Within the four research groups, the average duration of uninsurance among those with an uninsured spell was 7.7 months for working former recipients, 4.4 months for those who combined welfare and work, 3.9 months for nonworking current recipients, and 7.3 months for women who neither worked nor received welfare. These group differences were statistically significant ($p < 0.001$) and persisted when other factors, *including income*, were controlled statistically.

The Project on Devolution and Urban Change

Table 6.2

Health Insurance Status in Prior Month, by Welfare History Subgroups[a]

Health Insurance Status (%)	Full Sample	Currently on Welfare	On Welfare Past 12 Months, Not Now	On Welfare More Than 12 Months Ago
Uninsured	19.5 ***	6.1	30.5	38.6
Private insurance[b]	21.2 ***	9.9	21.0	41.0
Public insurance[c]	59.1 ***	84.0	48.3	20.2
Sample size	3,745	2,086	453	1,206

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Women in the Urban Change sample were categorized into one of the three groups based on their self-reported welfare histories.

[b] Private insurance includes people who received health insurance from an employer or union, had health insurance that was paid for directly by the respondent or someone in the household or immediate family (that is, private insurance not related to an employer or union), or health insurance that was provided by someone who did not live in the household.

[c] Public insurance includes Medicaid (or the state equivalent), a state health insurance plan, or any other plan not mentioned previously.

Another woman, who was caring for a daughter who was born with a serious seizure disorder, said that it was her daughter's health condition that led her to apply for welfare:

> *So with all of that, um, that's why I had to get on public assistance. Which was I believe in '81. No, in '80. 1980. Um, I went for a regular interview and one of the caseworkers there indicated — I told her that I wouldn't be down here, you know, getting welfare, if it weren't for her having, being so sick.* Tasha, Cleveland

Aside from losing time with their children (see Scott, Edin, London, and Mazelis, forthcoming), the most common concern that women expressed about moving from welfare to work was losing health insurance.[16] This theme came up repeatedly in the interviews, with many women indicating, specifically, that loss of Medicaid was an impediment to leaving welfare. Here are some examples of how the linkage between welfare and Medicaid (and, conversely, the association between low-wage work and uninsurance) influenced women's thinking about moving from welfare to work:

> *What interests me about this assistance is the Medicaid. That is what I worry about. If my kids get sick, what am I going to do, how much is it going to cost?* Carmen, Miami

> *Benefits are important to me. Like, my son is sick, so I need to be able to have medical benefits for him, for his prescriptions, medications, and his doctor's appointments. Today, I asked if I didn't have Medi-Cal anymore, how much was a doctor visit, and they said $250, depending. It could be less or more. So, I have to have medical benefits.* Liz, Los Angeles

> *I'd rather work. I'd rather be out there workin'. . . . I think if you found a good enough job, where, you know, that they will give you a little bit more, then you should go for it. You know, it's good to be on welfare sometimes, because you got the medical, and sometimes with a job, you might not get it. . . . You know, it's the only good part about it, that — they give you so much hassles. . . . I'd rather go out there and work and get a job than be goin' through a lot of hassles.* Sarah, Philadelphia

> *You know, welfare sucks, man, it does. If it weren't for the medical I wouldn't even, I wouldn't even be dealing with it, you know.* Katie, Cleveland

> *I like the idea of working, I really do. Because, you know, the only good thing about the welfare is your medical, you know, your medical. I don't care what type of job you have you cannot replace your medical.* Janice, Cleveland

The second broad theme that emerged in the baseline ethnographic data relates to the women's knowledge and understandings of transitional Medicaid benefits. In general, few women mentioned noncash health insurance benefits, or, if they did, they had vague, uncertain, or mistaken beliefs about the how this would work. Here are some examples of how women talked about their (mis)understandings of these new welfare policies and the ways that welfare is now supposed to work with them:

---

[16] At baseline, all the women in the ethnographic sample were receiving TANF benefits, which meant that they all were eligible for public health insurance benefits. Thus, in the baseline interviews, women expressed concern about losing health insurance in the future, when they transitioned from welfare to work, rather than concern about being uninsured or comparisons between public and private insurance.

> *I'm hoping that when I go next month, when I tell them that I'm going back to school, that they won't cut me off until I've gotten situated. Because, I know when you work, they're supposed to help you out still, and a lot of people told me they just cut them off. And if they do that, my kids won't have no medical. And I don't think that's right either.* Sarah, Philadelphia

> *I would lose, which is very important, which I can't lose, is the children's Medicaid. I can't pay it [health insurance]. She [caseworker] shouldn't take it away from me because I can't make enough to pay for it.* Dolores, Miami

> [Interviewer:] *What do you think will happen to your health coverage when you go back to work?*
> [Respondent:] *I will lose it.*
> [Interviewer:] *Has welfare talked to you any about that at all?*
> [Respondent:] *No, not yet.*
> [Interviewer:] *They haven't discussed that with you at all?*
> [Respondent:] *No.* Celena, Philadelphia

> *To my understanding, your cash benefits stop. They're not supposed to take your medical until medical starts at your new job and if it's not, if you can't afford to get your child coverage, you know, all the promises. I'm hoping that they keep all the promises, because if they do, it's good. If they don't, if for some reason they say, well, you're making a dollar too much, so we're not going to pay for your child's medical. You know, what's a dollar one way or another? You know. If you can't afford it, you can't afford it. Another dollar in your paycheck is not going to help you afford it in the first place.* Brenda, Cleveland

One recent study suggests that welfare leavers may not know about or understand how transitional benefits work because their caseworkers have not adequately explained it to them. In their study of welfare leavers in Cuyahoga County, Coulton et al. (2000) reported that most families who left cash assistance remained eligible for transitional Medicaid benefits; however, not all who were eligible retained benefits. Many of those who did not retain Medicaid benefits at the time they left cash welfare said they received a notice in the mail indicating that all their benefits were cut off.

The Urban Change ethnographic data provide examples of how misinformation about transitional benefits impeded women's movement from welfare to work. For example, one woman took a job and was told by her caseworker that she would lose her health insurance benefits. This woman got fired from the job (rather than quitting) so that she could remain on welfare and not be sanctioned:

> *I didn't even start my job yet and I called my caseworker, told him I got the job, told him the hours and the pay. We set up the appointment. I got my little form filled out.*

> *All of my check, OK, he took all of my check. I haven't even gotten a paycheck. I haven't even worked an hour yet at the new job. He takes half of my food stamps and tells me I have 30 days left for my food stamps and my medical card. I said, un uh, this isn't going to work. . . . I get more on welfare. I said I'll quit my job. He says you quit and you'll go 90 days without benefits at all. I said I'll get fired. I got fired. I purposely got myself fired, so I could keep my benefits, because they were more than my job. And at the same time I went and I found a job that paid cash under the table.* Brenda, Cleveland

In summary, the ethnographic data indicate that women clearly understood the linkages between welfare, work, and their own health insurance and that concerns about getting, keeping, or losing health insurance shaped to some extent their choices with respect to welfare and work. Anxiety about losing health insurance in the future was a topic that emerged consistently and spontaneously at multiple points in the baseline interviews. In fact, many women believed that their access to health insurance was contingent on welfare receipt, inasmuch as they thought it was unlikely that they could get jobs that offered health care benefits. Despite this concern, relatively few women had clear knowledge and understanding of transitional Medicaid benefits.

B. Respondent's Usual Source of Health Care

Respondent's Usual Source of Health Care: Highlights of the Findings

- Most women in the Urban Change survey sample (88.9 percent) reported that they had a usual source of health care.
- Welfare leavers, whether working or not, were the most likely not to have a usual source of health care (18.3 percent and 14.7 percent, respectively) and to report the emergency room as their usual source of care (3.7 percent and 4.6 percent, respectively).
- Most respondents indicated that their access to health care was the same as in the prior year (55.4 percent); women who received welfare (regardless of whether they worked or not) were particularly likely to report that their access was unchanged.

Having a usual source of health care is a second commonly used indicator of access to health care. Respondents to the Urban Change survey were asked whether, at the time of the survey, there was a place where they usually went when they were sick or needed advice about their health. Those who indicated that there was one place that they usually went were asked to specify the type of place from a list that included: doctor's office, health maintenance organization (HMO), hospital outpatient clinic, other clinic or health center, hospital emergency room, and some other place. Those who indicated that they had more than one usual source of care were asked to specify the place that they went most often. In keeping with how national estimates of the place of usual source of care are presented in the literature (Bloom et al., 1997), Urban Change respondents were classified as having a private doctor (including HMOs), clinic (hospital outpatient and other clinic combined), or emergency room.

As seen in Table 6.3, the vast majority of women in the Urban Change survey sample reported that they had a usual source of care at the time of the interview; only 11.2 percent lacked a usual source of care. This estimate is similar to that reported for the national population of women age 18-64 in 1993 (12.4 percent)[17] (Bloom et al., 1997). As seen in Table 6.3, women in the Urban Change survey sample were more likely to report a clinic as their usual source of care (44.4 percent) than to report a private doctor (41.1 percent) or an emergency room (3.4 percent).

Although most women had a usual source of care, there was significant variation across the four work/welfare groups that remained statistically significant when background characteristics were controlled. Welfare leavers in both the no-work, no-welfare group (18.3 percent) and the work-only group (14.7 percent) were more likely than current recipients (about 8 percent) to lack a usual source of care. Welfare leavers were also more likely to report the emergency room as their usual source of care. However, regardless of welfare receipt, women who worked were more likely than nonworking women to have a private doctor as their usual source of care, while nonworking women were more likely to use a clinic for their usual source of care.[18]

---

[17] This and other national estimates of health care utilization reported in this section of the chapter were derived from the 1993 Access to Care survey of the National Health Interview Survey (NHIS). The NHIS Access to Care survey was fielded for the first time in 1993, and it included questions about respondents' regular source of care, place of care, reasons for not having a regular source of care, difficulties in getting health services, and unmet needs for care (Bloom et al., 1997). Although these data are several years old, and despite the fact that these questions have been asked in subsequent rounds of the NHIS, these are the most recent national estimates available for working-age women.

[18] Although all these current usual source of care outcomes were significantly associated with work/welfare status when background characteristics were controlled, group differences became nonsignificant when a dichotomous indicator of prior month insurance status was included in the regression models. These supplemental analyses indicate that differences in current insurance coverage across the groups account for group differences in having a current source of care. This finding is consistent with evidence that persons with health insurance are more likely to have a usual source of care than persons who do not have health insurance (Bloom et al., 1997; Weissman and Epstein, 1994).

The Project on Devolution and Urban Change

Table 6.3

Usual Source of Health Care, by Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Current usual source of health care					
None	11.2 ***	14.7	8.7	7.1	18.3
Private doctor	41.1 ***	44.6	45.6	39.5	29.7
Clinic	44.4 ***	36.1	43.5	50.5	48.2
Emergency room	3.4 *	4.6	2.2	2.8	3.7
Change in usual source of care, past 12 months	15.8	15.3	16.1	16.8	13.3
Sample size	3,748	1,233	624	1,464	427

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

Figure 6.2 shows the percentage of women who reported a private doctor, clinic, or emergency room as their usual source of care *among those with a usual source of care*. Among all Urban Change respondents with a usual source of care, 49.9 percent reported a clinic, 46.2 percent reported a private doctor, and 3.8 percent reported the emergency room as their usual source of care. By comparison, among women age 18-64 in 1993 nationally who had a usual source of care, 86.2 percent reported a private doctor, 9.2 reported a clinic, 1.3 percent reported the emergency room, and 3.7 percent reported some other place as their usual source of care (Bloom et al., 1997).[19] Women in all four work/welfare groups were much more likely than working-age women nationally to have a clinic or emergency room as their usual source of care, which might have implications for the quality and the continuity of care they received.[20] While 85.9 percent of nonelderly women nationally had a private doctor as their usual source of care, the range in the Urban Change survey sample was from a high of 52.3 percent among working former recipients to a low of 36.4 percent among women who neither worked nor received welfare.

In addition to asking whether women in the Urban Change survey sample had a usual source of care and, if they did, where that place was, the survey also asked respondents to indicate whether, in the prior year, they had changed their provider or the place where they usually went for health care. Overall, 15.8 percent of the sample reported that they had changed their usual source of care in the prior year (Table 6.3). There were no significant differences in this outcome across the four work/welfare groups. The two most common reasons given for changing the usual source of care were health insurance and cost and quality (41.5 percent and 28.0 percent, respectively, of those who changed their source of care) (not shown in table).[21] Other reasons volunteered by respondents included being forced to change by the welfare agency (10.6 percent), job-related changes (2.5 percent), the need for a specialist of some sort (1.9 percent), and because their doctor was changed or moved (1.4 percent).[22]

---

[19] Women in the Urban Change survey sample were substantially more reliant on clinic-based care, and somewhat less reliant on emergency room care, than were poor persons nationally. Among nonelderly adults with a usual source of care and income below the poverty threshold in 1993, 61.5 percent reported a private doctor, 29.1 percent reported a clinic, and 4.6 percent reported the emergency room as their usual source of care (Bloom et al., 1997). The high rate of using clinic-based care in the Urban Change survey sample may reflect the tendency for safety net and other types of clinics to be concentrated in high-poverty urban areas.

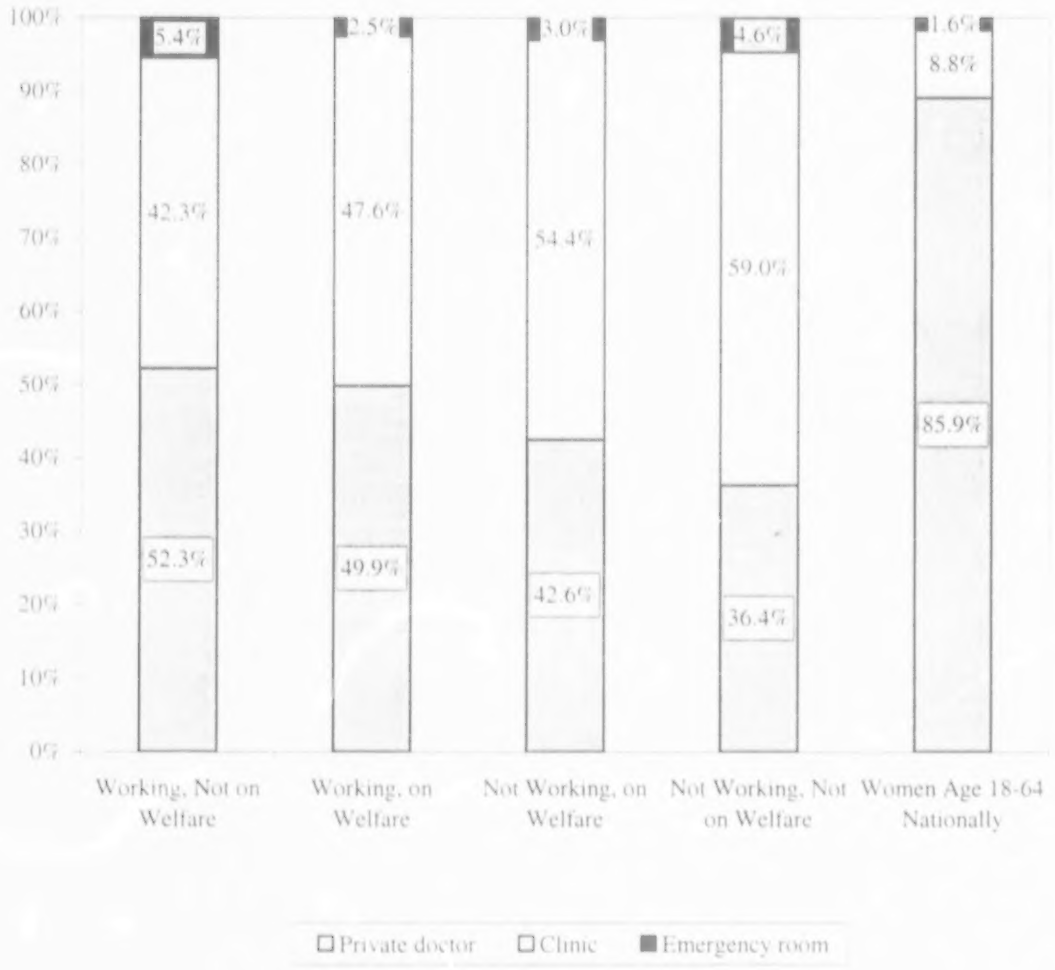
[20] Some women in the Urban Change ethnographic sample associated welfare and Medicaid with access to private physicians and specialists, which they preferred to clinics, and they associated leaving welfare with losing health insurance and having to rely on clinics again. For example, one woman responded to a question about whether she had used a clinic by saying: "You mean free health clinic? . . . I did last year, but not since I have been back on welfare, because, now I got the coverage, I go to a private doctor" (Lisa, Philadelphia).

[21] Analyses of data from the 1998-1999 Community Tracking Study indicate that 13 percent of persons with a usual source of care changed providers in the prior year (Reed, 2000). Overall, 24 percent changed because the provider was no longer available (for example, retired), 23 percent changed because of concerns about quality, 22 percent changed because of insurance reasons (that is, provider was no longer covered by plan, insurance plan changed, and other health insurance reasons combined), 12 percent changed because of convenience, 12 percent moved, 5 percent needed a particular doctor, and 2 percent reported other reasons.

[22] The question asked respondents whether "this change was mainly because of your health insurance or health care costs, the quality of care you received, or was it for some other reason?" Any "other reason" mentioned by respondents was recorded for subsequent analysis.

Figure 6.2

Location of Usual Source of Health Care, by Work and Welfare Status[a] and in U.S. Population



SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE: [a]Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

C. Family's Access to Health Care

In addition to worrying about their own health insurance, women are also often concerned about the health insurance of their children and other family members.[23] This is an important consideration because having an uninsured family member places the whole family at risk. In the event of a serious illness or accident, health care costs for an uninsured family member can have major consequences for the entire family.

Table 6.4 shows that in 11.2 percent of the families in the Urban Change survey sample, everyone was uninsured in the month before the interview; in more than one out of three families (35.7 percent), at least one person was uninsured in the month before the interview. These overall estimates mask substantial variability in family insurance status across the four work/welfare groups — differences that remained statistically significant even after group differences in household composition and other characteristics were controlled. Compared with welfare leavers, women who were still on welfare were much less likely to have family members who lacked health insurance. Among recipients, less than 3 percent lived in families in which everyone was uninsured.[24] However, in these families, it is noteworthy that 22-24 percent had at least one family member who was uninsured. By contrast, 20.9 percent of families of working former recipients were completely uninsured, and 49.8 percent contained at least one uninsured member. The families of women who neither worked nor received welfare were the most disadvantaged: 26.5 percent were entirely uninsured, and 57.3 percent included at least one uninsured person.

---

[23] Children's health insurance status is discussed in Chapter 7.

[24] As noted previously, all these welfare recipients were eligible for health insurance for themselves and their children. The fact that some reported that everyone in their family was uninsured likely reflects recent moves back onto welfare (along with misreporting).

The Project on Devolution and Urban Change

Table 6.4

Family-Level Access to Health Care, by Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Anyone in family uninsured, prior month[b]	35.7 ***	49.8	24.4	22.2	57.3
Everyone in family uninsured, prior month[b]	11.2 ***	20.9	1.8	2.6	26.5
Access to health care					
Harder than past 12 months	32.6 ***	37.5	28.8	27.9	40.3
Same as past 12 months	55.4 ***	47.4	60.4	62.2	47.3
Easier than past 12 months	12.0 ***	15.2	10.7	9.9	12.4
Sample size	3,733	1,227	624	1,463	419

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Family includes the respondent's husband or partner, her children, and any other household member she considers as immediate family and with whom she shares resources. Each person's health insurance status was determined, and these data were used to construct these outcomes.

Family's Access to Health Care: Highlights of the Findings

- Overall, 35.7 percent of women in the Urban Change survey sample were in families where at least one person was uninsured in the prior month, while 11.2 percent were in families where everyone was uninsured.
- Women who had left welfare, regardless of their employment status, were much more likely than current recipients to be in families in which one or all persons were uninsured; 50 percent or more of the welfare leaver families had at least one uninsured member.
- Most respondents indicated that their access to health care was the same as in the prior year; women who still received welfare were particularly likely to report unchanged access.
- Overall, 32.6 percent reported that their family's health care access had become more difficult. Higher percentages of welfare leavers than current recipients reported that their family's access to health care had become both harder *and* easier.

All respondents to the Urban Change survey were asked to provide a global assessment of their family's access to health care relative to the access they had in the prior year. Specifically, respondents were asked to indicate whether getting the medical care they and their family needed was easier, the same as, or harder than it was a year earlier.[25] As seen in Table 6.4, more than half (55.4 percent) indicated that their family's access was the same as in the prior year. Women who received welfare (regardless of whether they worked or not) were particularly likely to report that their access was the same. Although this was the most commonly reported response for each of the four work/welfare groups, there was significant group variation with respect to perceived changes in health care access. Both groups of women who had left welfare were more likely than current recipients to indicate that access to health care for their family was harder now than in the prior year. More than one out of three welfare leavers reported more difficult access. Women in these two groups were, however, also significantly more likely to report that their family's access to health care was easier than in the prior year. Former recipients who worked were most likely to indicate that their family had easier access to health care than in the prior year (15.2 percent).[26]

---

[25] Using national data from the Community Tracking Study, Lesser and Cunningham (1997) reported people's assessments of their current access to care in comparison with their access to care *three* years prior to the survey. Some 64 percent reported no change, 24 percent reported harder access, and 12 percent reported easier access. These estimates suggest that there was more change in health care access in a single year in the Urban Change population than in the general population over a period of three years.

[26] Women who reported that their health care access had become easier were more likely than others to have private insurance, and to be in jobs with health benefits, which at least in part explains the greater ease of access of women in the work-only group. Married women were also more likely than unmarried women to report that access had become easier, perhaps reflecting husbands' insurance coverage.

III. Respondent's Utilization of Health Care in the Prior Year

Respondent's Utilization of Health Care: Highlights of the Findings

- Overall, 84.1 percent of the women in the Urban Change survey sample had visited a doctor in the prior year, 62.2 percent had visited a dentist, and 42.1 percent had visited the emergency room.
- Women on welfare (regardless of whether they worked or not) were more likely than welfare leavers to have visited a doctor or dentist in the prior year.
- Working women, particularly working nonrecipients, were less likely to have had an emergency room visit than were women in the two nonworking groups.
- Overall, 14.7 percent of the women were dissatisfied with their health care; welfare leavers were more dissatisfied than women who were still receiving welfare.

Respondents to the Urban Change survey were asked to report the number of doctor, dentist, and emergency room visits they had made in the prior 12 months.[27] As seen in Table 6.5, 84.1 percent of respondents had made at least one visit to the doctor,[28] 62.2 percent had made at least one visit to the dentist,[29] and 42.1 percent had received care in the emergency room in the prior year. On average, in the prior year, women had made 6.0 visits to the doctor (7.1 among those who had a visit), 1.4 visits to the dentist (2.3 among those who had a visit), and 1.2 visits to the emergency room (2.8 among those who had a visit).[30]

Women's utilization of health care varied significantly across the four work/welfare groups, and these differences remained statistically significant when background factors were controlled. Women on welfare (regardless of whether they worked or not) were more likely than working former recipients to have had a doctor, dentist, and emergency room visit, and they had a higher average number of visits to each. For example, 87.8 percent of nonworking welfare recipients had at least one doctor visit and, on average, made 8.0 visits to the doctor in the prior year, while 80.0 percent of working nonrecipients made at least one doctor visit and had a group

---

[27] Respondents were asked first about dental visits and second about emergency room visits. The question regarding doctor visits explicitly instructed respondents to exclude the dental and emergency room visits that they had already included in their prior answers.

[28] An almost identical percentage of women age 18-44 nationally in 1996 (83.8 percent) had at least one physician contact in the previous year (National Center for Health Statistics, 1999, Table 72).

[29] Overall, in 1993, 60.8 percent of persons over the age of 25 nationally reported a visit to a dentist in the prior year. Among poor persons 25 years old or older, 35.9 percent had at least one visit to a dentist in the prior year, while among those at or above the poverty threshold, 64.3 percent had made at least one visit (Pamuk et al., 1998).

[30] These overall estimates of the average number of physician contacts are similar to those reported for poor women (6.8 visits) and near-poor women (6.0 visits) age 15-44 for the period 1993-1995 (Pamuk et al., 1998).

The Project on Devolution and Urban Change

Table 6.5

Health Care Utilization and Satisfaction, by Work and Welfare Status^a

Outcome	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Had 1 or more visits, past 12 months (%)					
Doctor	84.1 ***	80.0	86.7	87.8	79.8
Dentist	62.2 ***	60.3	68.2	64.1	52.9
Emergency room	42.1 ***	36.3	42.2	45.8	45.9
Average number of visits per year					
Doctor	6.0 ***	3.9	5.5	8.0	6.1
Dentist	1.4 **	1.4	1.5	1.5	1.1
Emergency room	1.2 ***	0.9	1.1	1.5	1.3
Had more than 5 visits, past 12 months (%)	29.1 ***	18.1	27.8	39.0	29.3
Currently dissatisfied with health care^b (%)	14.7 **	16.1	14.8	12.4	19.1
Sample size	3,755	1,238	625	1,465	427

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

^{a}Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

^{b}Combines "very satisfied" and "somewhat satisfied."

average of 3.9 visits in the prior year. Women who neither worked nor received welfare had particularly low utilization of dentists, with only 52.9 percent having made a visit in the prior year (compared with 60.3-68.2 percent of the women in the other groups).[31]

Table 6.5 also shows the percentage of women in the Urban Change survey sample who had more than 5 doctor visits in the previous 12 months. Five visits was used as the criterion because, in 1996, women in their childbearing years had an average of 4.3 contacts with physicians either in offices or in hospitals (National Center for Health Statistics, 1999, Table 71); therefore, 5 was considered above average for this age group. Nearly one-third of the sample had 5 or more physician visits. More than twice as many current nonworking recipients (39.0 percent) had this many visits as did working former recipients (18.1 percent).

All women in the Urban Change survey sample were also asked to rate their satisfaction with the health care they and their family members had received in the prior year. Generally, only a minority of Americans are dissatisfied with the health care they receive (Reed and St. Peter, 1997), and this was also the case in the Urban Change sample. However, as seen in Table 6.5, 14.7 percent of women reported that they were currently dissatisfied with their health care, compared with 10.0 percent in the general population, based on data from the Community Tracking Study (Reed and St. Peter, 1997). There was significant variation across the four research groups, which remained statistically significant when background factors were controlled. Women who received welfare (regardless of whether they worked or not) were less likely than welfare leavers to be dissatisfied with their health care. Women who neither worked nor received welfare were the most likely to be dissatisfied with the health care they and their families had used in the prior year (19.1 percent), which is consistent with the fact that these women had substantial need and yet were most likely to be uninsured and to have access problems.[32]

---

[31] Supplemental analyses indicate that these utilization patterns reflect group differences in health insurance coverage over the prior year and, to a lesser extent, health status. In the regression models that included only the background characteristics, work/welfare status remained significantly associated with prior-year utilization of doctors, dentists, and emergency rooms (that is, had a visit versus did not). When a continuous indicator of the number of months that respondents were covered by insurance in the prior year was included in the model, the relationship between work/welfare status and having had at least one doctor visit and having had at least one dental visit, respectively, became statistically nonsignificant. Having visited the emergency room in the prior year remained significantly associated with work/welfare status. When current health status, measured by scores on the physical health component of the SF-12, was included in the models (not including health insurance coverage in the prior year), work/welfare group differences remained statistically significant for all three dichotomous utilization outcomes. In a final set of analyses that included both the number of months uninsured in the prior year and the SF-12 scores, work/welfare group differences were nonsignificant for all three utilization outcomes. Thus, it appears that group differences in health insurance coverage accounted for differential utilization of doctors and dentists in the prior year, whereas a combination of need and lack of access explained group differences in emergency room utilization.

[32] Although the relationship between work/welfare status and dissatisfaction with health care remained statistically significant when background factors were controlled, this relationship became nonsignificant when a continuous indicator of the number of months uninsured in the prior year was included in the regression model. Although the survey question asked about dissatisfaction with the medical care the respondent and her family had received in the prior year, this supplemental analysis suggests that, in response to this question, women were in part rating their dissatisfaction with their own lack of access to health care.

Women in the ethnographic sample were not asked systematically about their health care utilization,[33] nor were they asked to rate their satisfaction with health care. However, some women volunteered information about hassles they had experienced with a health care provider or in negotiating the payment of some bill. For example, one woman, who went to the emergency room when she was bleeding from a miscarriage, talked about the difficulty she had when she was presented with a bill for five thousand dollars because neither she nor the emergency room staff had called to obtain authorization for the visit. Other women talked in passing about the fact that not all their prescriptions were covered, or they mentioned other relatively minor dissatisfactions with their health care coverage or provider.

Some respondents, however, talked directly about poor treatment they received because they were on Medicaid. For example, one woman said:

> *I went in one time, um, I don't know what it was I had. I think it was a gallbladder attack and, um, I gave them my medical card. . . . This doctor comes in and he said, you know, you can wait for a while because you're not paying us out of your pocket. I was like, wait, I don't have to wait and I got up and I left and come to find out, that I had, um, gallstones. I went to a different one. I had gallstones and I actually hit the floor in pain and this doctor would not do anything because he didn't want to be paid by welfare, but you have a lot of bad experiences.* Janice, Cleveland

Another woman said:

> *So, um, that really made me mad. That all these doctors, they were just sitting and not doing anything. They didn't care. It wasn't their kids. They don't care. Especially when you're on welfare and stuff. And they know, when they see your insurance, they automatically know you're on welfare, because you have Medi-Cal. They put other people ahead of you. They don't care. Like, for instance, one time I was at the GI doctor, at his office waiting. I had went in, she told me to sign in. Then this other lady came in. Her . . . my appointment was before hers. She was all friendly with her and everything. I didn't think nothing of it. But, then she said, okay, you got . . . um, she had to pay a copayment, of I don't know how much she paid for this visit. And she said, should I write you a check? And she said, yeah, that's fine, just make it out to so and so. So she wrote it, and she goes, okay, you can go in. And I got really mad. And she offered her coffee and all this stuff. I was really mad.* Norma, Los Angeles

As women go to work and, potentially, lose health insurance, their satisfaction with the health care available to them and their family members may change (see, for example, Coulton et al., 2000). Losing health insurance and access to needed care was certainly something the women in the Urban Change ethnography were concerned about at baseline, as discussed earlier in this chapter. It is expected that the longitudinal ethnographic data that are being collected will allow for an examination of how welfare-to-work transitions and related changes in women's lives affected their access to and satisfaction with health care.

---

[33] Nevertheless, women in the ethnography mentioned substantial health care use, ranging from routine checkups to emergency care. Some women used health services for the ongoing care of such chronic conditions as asthma, breast cancer, hypertension, anemia, arthritis, a herniated disc, carpal tunnel syndrome, and Graves' disease. Others reported seeking care for acute and infectious conditions, such as bronchitis, flu, and kidney infections. Women also discussed care for reproductive health, substance abuse, and mental health problems. The few women who mentioned emergency room use said they were seeking care for crises, such as a miscarriage or a gallbladder attack.

IV. Unmet Needs for Health Care

Unmet Needs for Insurance and Health Care: Highlights of the Findings

- Welfare leavers — especially ones who were not working — were significantly more likely than women still on welfare to report both individual- and family-level unmet needs for health care.
- Women who neither worked nor received welfare were particularly likely to be in fair or poor health *and* to have had health care access problems and low health care utilization. Moreover, their families' unmet need for medical and dental care was more than twice the rate of current recipients.
- Over 40 percent of working nonrecipients experienced unmet medical or dental needs in their families, compared with 19-20 percent of women who received welfare.

Unmet need for health care is a particularly important health outcome because it measures the extent to which people who need care do not receive it (Aday and Andersen, 1974; Andersen and Aday, 1978). Unmet need for health care combines two dimensions: need and lack of utilization. By definition, those who need care but do not use it have some barrier to health care. Thus, estimates of unmet need provide a means to assess problems with access to health care.

The Urban Change survey included two questions that asked whether anyone in the respondent's family needed to see a doctor or dentist, respectively, in the prior year, but had not done so because the family could not afford it. Although the survey did not ask about the respondent's personal unmet needs for health care, it was possible to derive three individual-level outcomes that gauge the respondent's own unmet need for access to and utilization of health care. These outcomes are (1) the respondent was in fair or poor health and was uninsured in the month prior to the interview; (2) the respondent was in fair or poor health and had no usual source of care; and (3) the respondent was in fair or poor health and had not seen a doctor in the prior year.[34] Each of these outcomes is examined in Table 6.6.

---

[34] The assumption underlying these measures and their conceptualization as indicators of unmet need is that persons in fair or poor health are particularly in need of access to and utilization of health care. For those is fair or poor health, lack of access (that is, not having insurance or a usual source of care) and lack of utilization (that is, not seeing a physician) are presumed to represent forms of unmet need and hardship.

194

The Project on Devolution and Urban Change

Table 6.6

Unmet Need for Health Care, by Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Respondent in fair to poor health and:					
Uninsured in the prior month	5.4 ***	7.7	1.7	2.1	15.3
Had no usual source of care	3.1 ***	3.3	1.2	2.4	7.1
Had no doctor visit in the prior year	3.8 ***	4.8	2.3	2.7	6.9
Anyone in family, in past 12 months:[b]					
Needed doctor but could not afford it	23.4 ***	32.4	13.9	15.1	39.5
Needed dentist but could not afford it	25.0 ***	35.0	15.0	15.9	41.8
Had any unmet medical or dental need	29.7 ***	40.5	18.7	20.3	46.7
Sample size	3,761	1,239	626	1,468	428

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

Sample sizes for respondents stating they were in fair to poor health were as follows: Full Sample = 922; Working, Not on Welfare = 207; Working, on Welfare = 121; Not Working, on Welfare = 450; Not Working, Not on Welfare = 144.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Family includes the respondent's husband or partner, her children, and any other household member she considers as immediate family and with whom she shares resources. Each person's health insurance status was determined, and these data were used to construct these outcomes.

There was substantial variation in unmet needs for medical and dental care across the four work/welfare groups, and the variation remained statistically significant when background factors were controlled. Reflecting their higher likelihood of being insured and their better access to health care, the families of women who received welfare (regardless of whether they worked) had consistently lower levels of unmet needs. The families of women who neither worked nor received welfare consistently had the most unmet needs. Approximately 40 percent of the welfare leavers had an unmet need for medical or dental care in their families, and nearly half (46.7 percent) had some unmet need for either type of care in their families in the prior year. Unmet needs in the families of welfare leavers were more than twice as high as they were in the families of women who received welfare.[35]

A. Respondent's Unmet Need for Access to and Utilization of Health Care

Overall, some 25.5 percent of the women in the Urban Change survey sample reported they were in fair or poor health. Among those not in good health, about one out of five (5.4 percent of the full sample) did not have insurance to address their health care needs in the month before the interview. As shown in Table 6.6, 3.8 percent of the full sample were not in good health yet had not seen a doctor in the prior year, and 3.1 percent who were in fair or poor health had no usual source of care. There were significant group differences for each of the three derived indicators of the women's unmet need for health care, and the pattern was consistent. Welfare leavers had higher rates of unmet need than those who still received welfare (regardless of whether they worked or not). Former recipients who did not work were particularly disadvantaged, with 15.3 percent being in fair or poor health and uninsured, 7.1 percent being in fair or poor health and lacking a usual source of care, and 6.9 percent being in fair or poor health but not having a doctor visit in the prior year. The rates for this group were about twice the corresponding rates for leavers who worked — a group who were generally healthier (see Chapters 4 and 5) but who also had a high rate of uninsurance (see Table 6.1).

B. Family's Unmet Need for Medical and Dental Care

In addition to the respondent's unmet need outcomes, Table 6.6 also presents estimates of the family's unmet needs in the prior year. As seen in Table 6.6, approximately one in four women reported unmet needs for medical care or dental care in their families in the prior year. Interestingly, the percentage reporting *any* unmet need (medical and dental combined) is 29.7 percent, which is not much higher than the prevalence estimates for each type of care. This indicates that there was substantial overlap in terms of met and unmet needs for medical and dental care, with most families experiencing either both types of unmet need or neither type.[36]

---

[35] Work/welfare group differences in each type of unmet need and any unmet need remained statistically significant even when controlling the variables measuring whether anyone in the family was uninsured in the prior month, the physical health component of the SF-12, and whether the respondent had a child with a physical, learning, or mental health condition that restricted the child's participation in activities done by most children of that age. These latter two variables were included in an attempt to approximate family-level need for care.

[36] Overall, 18.7 percent experienced both types of unmet needs, while 11.0 percent experienced one or the other type of need but not both. Among those with any unmet need for medical or dental care, 62.9 percent experienced unmet needs for both medical and dental care.

Although women in the Urban Change ethnography were asked explicit questions about whether they were unable to get needed medical or dental care for themselves or their children in the prior year because they could not afford it, there was not a lot of unmet need reported at baseline. This is not surprising, inasmuch as all the women were on Medicaid at baseline, and they seemed generally satisfied with the health care they received. However, in the course of telling interviewers about the things that had happened to them, or in response to explicitly probing questions, women referenced delayed or unmet needs that they had had to contend with in the past or worried about facing in the future. The one thing that women did mention regularly was the unmet need for prescription drugs, either because they were off welfare (and thus had no health insurance) or because Medicaid would not pay for the prescription. For example, when asked if she had needed to buy medicine or other health products but didn't because she couldn't afford it, one woman said:

> [Respondent:] *My breathing medicine . . . [unintelligible comment].*
> [Interviewer:] *So, they won't pay for your asthma?*
> [Respondent:] *No, it's breathing pills. They say that it's not a medical necessity. Breathing's not medical.*
> [Interviewer:] *Ha-ha. So, how often would you say you go without?*
> [Respondent:] *Every month.*
> [Interviewer:] *Do you have it for part of the month or do you just go without it all the time?*
> [Respondent:] *Go without it. I don't have the sixty-two dollars to pay for it.*
> [Interviewer:] *For a month?*
> [Respondent:] *M-hm.*
> [Interviewer:] *Is that a prescription, or is that you can buy it over the counter?*
> [Respondent:] *Prescription. They claim they pay on all prescriptions.*
> [Interviewer:] *And they won't.* Laura, Cleveland

V. Relationship Between Families' Unmet Needs and Selected Women's Health Outcomes

Families' Unmet Needs and Selected Women's Health Outcomes: Highlights of the Findings

- Families' unmet needs for medical or dental care in the Urban Change survey sample were significantly and positively associated with more material hardships, worse physical and mental health statuses, worse access to health care, higher use of the emergency room, and lower satisfaction with health care.

Because unmet need for health care is a critical and policy-relevant indicator of problems with health care access, it is important to examine whether and how unmet need is associated with other forms of material hardship and with health outcomes. As seen in Table 6.7, family unmet needs for health care (medical and dental combined) were significantly associated with a broad range of women's health outcomes that have been considered in previous chapters of this report. In fact, unmet needs differentiated women on all the outcomes reported in this table.

In the literature, unmet needs for health care are often included in discussions of material hardships. In the Urban Change survey sample, families who had unmet needs for medical or dental care were significantly more likely to be food insecure (64.0 percent versus 42.4 percent) and to have experienced three or more material hardships (35.3 percent versus 25.3 percent) than were families who did not have unmet needs.

Measures of women's own physical and mental health statuses were consistently related to their family's unmet needs. Women whose families had unmet needs for medical and dental care were significantly more likely than other women to be in fair or poor health, to have a health condition that limited their ability to work, to have been physically abused in the prior year, to be highly stressed, and to be at high risk for depression. These findings are consistent with the fact that people who have health problems also have greater need for health care than people without health problems.

Women's own health insurance coverage and having a usual source of care were, as would be expected, significantly associated with reduced family unmet need for health care. Women who reported unmet health care needs were much more likely than those who did not to indicate that they had been uninsured at some point in the prior year (61.2 percent versus 17.0 percent).[37] Respondents whose families had unmet needs were also significantly more likely to report that they did not have a usual source of care (19.9 percent versus 7.5 percent) and that the emergency room was their usual source of care (6.3 percent versus 2.2 percent). Finally, women whose families had unmet needs for care were much more likely than others to have reported that health care access was harder than in the prior year (53.8 percent versus 23.7 percent), which is likely to be an issue for those women who leave welfare without health insurance benefits (Coulton et al., 2000; Families USA Foundation, 1999, 2000; Reidy, 1998).

Women whose families did *not* have unmet health care needs were more likely to have had a doctor visit (87.7 percent versus 75.8 percent) and a dentist visit (68.5 percent versus 47.5 percent), respectively, in the prior year, while those whose families did have unmet needs were more likely to have had an emergency room visit (44.7 percent versus 41.1 percent). Taken together, these results confirm that access to and utilization of health care are associated with reduced unmet needs for medical and dental care and reduced utilization of emergency rooms (both in general and as a usual source of care).

---

[37] Consistent with these findings is that women whose families had unmet needs were more likely than women whose families did not have unmet needs to report out-of-pocket medical and dental expenditures in the prior year (56.7 percent versus 32.8 percent) (not shown). The higher likelihood of having expenditures in these families is likely to reflect the fact that families with unmet needs are more likely to be uninsured and therefore must pay for medical and dental care themselves.

The Project on Devolution and Urban Change

Table 6.7

Selected Material Hardship and Health Outcomes, by Unmet Need for Medical or Dental Care

	Family Had Unmet Medical or Dental Need, Past 12 Months	
Outcome (%)	Yes	No
Food insecure, past 12 months[a]	64.0 ***	42.4
Has 3 or more material hardships[b]	35.8 ***	24.9
Reports fair to poor health	32.4 ***	22.5
Scored less than 40 on physical component of SF-12[c]	33.7 *	30.2
Health limits ability to work	29.0 ***	21.9
Physically abused, past 12 months[d]	10.5 *	8.0
Stressed, prior month	61.7 ***	45.2
High risk of depression[e]	32.4 ***	25.0
Ever uninsured, past 12 months	61.2 ***	17.0
Current usual source of health care		
None	19.9 ***	7.5
Private doctor	34.9 ***	43.7
Clinic	38.9 ***	46.6
Emergency room	6.3 ***	2.2
Health care utilization, past 12 months		
1 or more doctor visits	75.8 ***	87.7
1 or more dental visits	47.5 ***	68.5
1 or more emergency room visits	44.7 *	41.1
Currently dissatisfied with health care[f]	26.6 ***	10.0
Access to health care harder now than a year ago	53.8 ***	23.7
Sample size	1,120	2,646

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

Table 6.7 (continued)

[a] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[b] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[c] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[d] The respondent reported that she was hit, slapped, or kicked.

[e] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

[f] Combines "very satisfied" and "somewhat satisfied."

Finally, there was a strong association between unmet needs for medical and dental care and satisfaction with health care. Women who had unmet medical and dental needs in their families were much more likely to be dissatisfied with their health care (26.6 percent versus 10.0 percent).

VI. Discussion

Access to and utilization of needed health care services are critical determinants of individual and family well-being. In the presence of needs for preventive or ameliorative health care services (because of health risks or problems), having health insurance and a usual source of care enable utilization by providing financial access and by promoting familiarity, convenience, confidence, and satisfaction. Unmet need for health care results from the combination of health risks or problems and barriers to access.

Lack of health insurance is the predominant barrier to accessing needed health care in the United States. Because of the known linkages among welfare, low-wage work, and health insurance coverage, there has been substantial concern that one of the unintended consequences of welfare reform would be an increase in the percentage uninsured. Despite the expansion of Medicaid eligibility and the availability of transitional health insurance benefits, there is considerable evidence that many who leave welfare do not retain the health insurance benefits for which they are eligible. This has led some to conclude that welfare reform has contributed to an increase in the uninsurance rate in the United States (Families USA Foundation, 2000), and it has given rise to programmatic initiatives aimed at locating eligible nonrecipients for the purpose of reenrolling them on Medicaid.

Consistent with expectations derived from the literature, then, the current and former welfare recipients in the Urban Change survey sample had very different profiles in terms of health care access, utilization, satisfaction, and unmet needs. Those women who received welfare at the time of the survey were universally eligible for public health insurance benefits, and they thus had much lower rates of being uninsured in the month or year prior to the survey than did welfare leavers, who had to obtain health insurance through work, kin, or the market. Current recipients were also more likely than welfare leavers to have had full-year coverage. Partly as a result of their higher level of insurance coverage, they were less likely than welfare leavers to report that they lacked a usual source of care or that they relied on the emergency room as their usual source of care. Also, welfare recipients were more likely than welfare leavers to have had a doctor or dentist visit in the prior year, and they were more likely to be satisfied with their health care. However, since utilization of health care is partly a function of health status (as well as health care access), welfare recipients and women who neither worked nor received welfare used emergency rooms and had more annual doctor visits than did working nonrecipients. This undoubtedly reflects the much better health status of working former recipients, as documented in previous chapters. Finally, welfare recipients had much lower levels of personal and family unmet needs for health care than welfare leavers did. Women who had left welfare and were not working, and their families, appear to have been particularly disadvantaged.

Unmet family needs for medical or dental care were associated with a broad range of health outcomes described in previous chapters, and they were associated with food insecurity and higher levels of material hardships. This is not surprising, given that unmet needs for health care are, per se, a form of material hardship. However, it was also shown that women who were themselves more disadvantaged with respect to health outcomes were more likely to have unmet needs for medical or dental care in their families. Higher levels of unmet need were observed in the families of women who themselves were in worse physical and mental health, women who had been physically abused in the prior year, women who themselves had problems with access to health care, women who were more reliant on emergency rooms for care, and women who were less satisfied with their health care.

Chapter 7

Children's Health Outcomes

I. Introduction

The majority of children in the United States are healthy, and many indicators of child well-being have shown improvement over the past 10 to 15 years. For example, between 1985 and 1996, there were declines in the infant mortality rate, the child death rate, and the rate of teenage deaths by accidents, homicides, and suicides (O'Hare and Ritualo, 2000). Nevertheless, many children are at high risk of poor health outcomes.

Variation in children's health status, like that of adults, has consistently been found to be associated with poverty and low socioeconomic status. Data from both interview and health examination surveys indicate that, compared with children from more affluent families, children from poor families experience a disproportionate burden of accidents, injuries, and early death; more limitations of activity; a higher risk of severe illness, chronic conditions, and mental health problems; and less favorable developmental scores (Newacheck, 1994; Flores, Bauchner, Feinstein, and Nguyen, 1999; Miller, 1998, 2000; McLeod and Shanahan, 1996; Montgomery, Kiely, and Pappas, 1996). Furthermore, several studies of welfare recipients have shown that a disproportionately high number of welfare families have children with disabilities, health problems, and special needs (see, for example, LoPrest and Acs, 1996; Meyers, Lukemeyer, and Smeeding, 1996).

Low-income children, like low-income adults, are also especially likely to have health care access problems. Being poor or nearly poor is strongly related to children's being uninsured (Holl et al., 1995; U.S. Bureau of the Census, 1999b). Children in poor families are more likely than those in more advantaged families to have unmet medical and dental care needs; to lack a regular source of medical care; to delay medical care because of their parents' cost concerns; and not to be fully immunized (Flores et al., 1999; Simpson, Bloom, Cohen, and Parsons, 1997; Newacheck, Hughes, and Stoddard, 1996; Bates and Wolinsky, 1998; Vargas, Crall, and Schneider, 1998).[1] As with adults, children's lack of health insurance and health care access are linked: Children who are uninsured (even after controlling for family income) have greater health care access problems than insured children (Simpson et al., 1997; Newacheck et al., 1996, 1999; Stoddard, St. Peter, and Newacheck, 1994; Overpeck and Kotch, 1995).

The Urban Change survey asked mothers two types of questions about their children's health. First, mothers were asked if *any* of their children had certain health problems. For example, mothers were asked if any of their children had been hospitalized in the previous year. Second, there were also questions about a specific focal child. As noted in Chapter 2, focal children were selected from those children in the household who were younger than age 6 and from those age 12-18.[2] For example, mothers were asked to rate the overall health of focal children. This chapter presents survey data for both types of questions, as well as ethnographic data about children's health and health care.

---

[1] Poor children are, however, more likely to be hospitalized and to have longer hospital stays (National Center for Health Statistics, 1999), presumably reflecting greater need rather than greater access.

[2] See Table 2.8 for selected characteristics of the focal children.

II. Children's Health Status

Children's Health Status: Highlights of the Findings

- A substantial minority of mothers in the Urban Change survey sample had at least one child with a limiting health condition (15.3 percent) or an illness or disability that made it difficult for the mother to work (19.8 percent).
- Mothers who were not working (whether or not they were on welfare) were significantly more likely than working mothers to have a child with a health problem.
- Women who were not working were also more likely than working mothers to describe a preschool-age child as being in fair or poor health.
- In general, former recipients who were working had children with the fewest health problems.

Chronic health problems in children result in school absences and an ongoing need for medical attention. Managing their children's chronic conditions places many demands on parents and is often stressful. Caring for an ill child may result in work absences or tardiness among parents who are able to work — or may constrain parents' ability to take or keep a job.

As shown in Table 7.1, 15.3 percent of the women in the Urban Change survey sample reported that they had at least one child with a physical, learning, mental, or health condition that limited the child's participation in the usual kind of activities done by same-age children.[3] A slightly higher percentage of mothers (19.8 percent) said that at least one child had an illness or disability that was demanding and made it difficult for the mothers to go to work or school.[4] (Among the women who reported having a child whose health constrained their ability to work, one out of four had more than one child with such an illness or disability.) For both these outcomes, the prevalence was higher among women who were not working. For example, 25.0 percent in the welfare-only group, compared with 13.0 percent in the work-only group, said that their children's health problems made employment difficult. These group differences remained significant when the mothers' background characteristics were controlled — and even when total family income in the prior month was controlled.

---

[3] Among women with children in school, 18.0 percent reported that one or more child received special education, and group differences were again significant: 13.0 percent of the women in the work-only group, 20.8 percent of those in the work-and-welfare group, 21.0 percent of those in the welfare-only group, and 17.3 percent of those in the no-work, no-welfare group had a child in special education ($p < .001$).

[4] The average age of the child with a health condition limiting the child's activities was 9.5, while the average age of the child with an illness or disability affecting the mother was 8.4.

The Project on Devolution and Urban Change

Table 7.1

Children's Health Status and Health Risk Behaviors, by Mother's Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Any child:					
With a condition that limits child's participation in usual activities for same-aged children	15.3 ***	10.8	13.6	18.7	19.0
With an illness/disability that limits mother's work or school participation	19.8 ***	13.0	18.6	25.0	23.1
In household received SSI, prior month	5.7 ***	2.9	4.9	7.7	8.3
Had an accident or injury requiring medical attention, past 12 months	18.5	18.8	19.4	18.1	17.9
Younger focal child rated in fair to poor health[b]	7.8 **	5.0	7.1	9.8	9.6
Older focal child:[c]					
Rated in fair to poor health	11.7	10.5	9.3	13.7	11.2
Currently smokes cigarettes	6.4 *	3.6	6.0	7.8	9.0
Sample size	3,741	1,232	624	1,458	427

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

All child outcomes utilize maternal reports.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Younger focal children were selected from those children in the household age 6 or younger.

[c] Older focal children were selected from those children in the household between ages 12 and 18.

About 6 percent of the women had at least one child who received disability payments (Supplemental Security Income, or SSI) in the month prior to the interview. Consistent with the pattern for mothers' reports of their children's health problems, women who worked (especially those in the work-only group) were less likely than women who did not work to be getting SSI payments on behalf of their children.

Mothers were also asked if any of their children had had an accident, injury, or poisoning that required medical attention in the prior year. Nearly one out of five mothers reported that this was the case.[5] The four work/welfare research groups had similar rates of accidents and injuries. On average, children who had such an accident or injury were 7.9 years old.

Mothers who had a preschool-age focal child were asked to rate that child's health on the following scale: excellent, very good, good, fair, or poor. For the sample as a whole, 7.8 percent said their young children were in fair or poor health; 74.6 percent said their children were in very good or excellent health.[6] Women in the two nonworking groups were significantly more likely than working mothers to report that their preschooler was in fair or poor health. A somewhat higher percentage of women (11.7 percent) reported that their *older* focal child was in fair or poor health, but in this case the group differences were not statistically significant. The overall rate is substantially higher than the national rate of 2.6 percent (4.2 percent for blacks, 2.3 percent for whites) for children age 5-17 rated in fair or poor health in 1996 (National Center for Health Statistics, 1999).

As reported by their mothers, 6.4 percent of the adolescents smoked cigarettes (none of those age 12 and, at the other extreme, 28.7 percent of those age 17). Mothers who themselves were smokers were significantly more likely to report having children who also smoked ($p < .001$). There were group differences in the smoking habits of adolescents in the four groups — differences that persisted when the mothers' background characteristics and the child's age and gender were controlled. Children of women in the work-only group (3.6 percent) were less likely to smoke than children in the other groups, especially children in the no-work, no-welfare group (9.0 percent).[7] Overall then, children of mothers in the work-only group had the most favorable health status outcomes, consistent with findings for the mothers themselves (Chapter 4).

The baseline ethnographic interviews asked mothers a few broad questions about their children's health and unmet needs for health care. Answers to these questions provided a substantial amount of qualitative information about children's health and well-being. In other parts of the interviews, however, women also volunteered information about their children's health, which reflects the salience of these concerns to the mothers.

---

[5] Although the survey did not ask about child abuse or neglect, it is noteworthy that the incidence of accidents and injuries to children was significantly related to whether the mother had herself been physically abused. Some 26.5 percent of the women who reported physical abuse in the prior year, compared with 18.2 percent of those who did not, had children who had experienced an accident or injury requiring medical attention ($p < .001$).

[6] Of the Urban Change mothers, 9.8 percent said that their children age 2-5 (that is, excluding 6-year-olds) were in fair or poor health, compared with 2.6 percent for children under age 6 nationally in 1996 (National Center for Health Statistics, 1999).

[7] Mothers in the Urban Change survey sample may have underestimated the smoking habits of their adolescent children. According to national data, some 15-16 percent of African-American and Hispanic adolescents age 12-17 smoked in 1997 (U.S. Department of Health and Human Services, 1999b).

Many of the women in the Urban Change ethnographic sample reported that their children had physical or mental health problems. While some women had one child with significant health problems, it was not unusual for women to have two or more children who had special health care needs. Mothers referenced a variety of health concerns, ranging from the minor colds and accidental injuries that children often get, to the more serious health problems related to congenital conditions or chronic diseases. In the interviews, some health concerns were noted more regularly than others. Several mothers talked about children with, for example, asthma (often so severe that the children were hospitalized periodically or qualified for SSI); developmental disabilities attributed to such causes as oxygen deprivation at birth, premature birth, autism, and brain damage from a severe reaction to an immunization; seizure disorders; attention deficit hyperactivity disorder (ADHD); and lead poisoning.[8] Here are some examples of how respondents spoke about their children's health problems:

> *He born a very, very sick baby. He almost died. He was in intensive care for a month. . . . It was just, when they took him out, he had purple nails. . . . We didn't know what was wrong. One time, he was on the swing, he looked pale. Not a normal baby. So he was sent to the emergency and they took him in for a week. . . .He had to go back again and then the doctor told me he had to stay longer. . . . They had to bring in specialists for the stomach. 'Cause he had, he was eating regularly. Eating his bottle, since I wasn't breast feeding. His stomach was growing and his arms were getting thinner. So he was there for a whole month, in the intensive care.* Monica, Los Angeles

> *My youngest son, the 11-year-old, has a real severe case of ADHD. He bounces off the wall. And my daughter, she's slow. She's not retarded, but she's slow. She's got an IQ of 70. She had, the oxygen was cut off when she was born. She was a traumatic birth. Plus, then, she had spinal meningitis when she was 3 and that shot her temperature up to like 106. So, she had it rough the first couple of years, and I think that is why she is the way she is.* Olivia, Cleveland

> *With my baby Gabriel . . . I have him on SSI, because of the problem that he lacks oxygen to the brain. . . . He has retardation. . . . The baby grew a lot, sugar, and diabetes . . .and they had to induce labor eleven days early. . . . When the baby wanted to be born, he was tilted and could come out by the shoulders. They pushed him back and did a cesarean. And so, the doctors that are examining him today say that possibly for a lapse of a second, the baby stopped [breathing], but he revived him again and in that piece that the baby stopped breathing, stopped living, oxygen didn't get to his brain. . . . He has problems that he can't catch a ball. He can't tumble. He can't go down the stairs . . . that is why they are helping him a lot, because he is in the second grade and he cannot put words together.* Teresa, Los Angeles

---

[8] Other health problems mentioned by only one or two ethnographic respondents included cancer, heart problems, cerebral palsy, and HIV infection. Several women also reported recent severe accidents and injuries that had resulted in severe burns and broken bones.

> *I had a problem with him. . . . I had to put him away at the age of 3, the Horsham Clinic, psychiatric unit, at the age of 3. . . . [He stayed] for a month because he used to set fires, I am telling you he was ready to kill somebody and now they want me to get him back in therapy.* April, Philadelphia

> *Well, my son, he got, they say he got a mild case of cerebral palsy. . . . He didn't start walking until he was almost 2 and they say he might be a little mentally delayed.* Glenda, Cleveland

Other constellations of health problems were mentioned in these interviews. For example, one mother talked about needing to constantly monitor a child diagnosed with severe ADHD, bipolar disorder, and schizophrenia who had suicidal and homicidal ideation.[9] Another mother spoke of a child who had been hit by a car, was in a coma for two months, and was still hospitalized at the time of the interview, attempting to recover his ability to move, eat, and walk. Another mother, in Miami, described the mental health problems of two of her children — one reclusive son suffering from depression and a daughter with psychological problems stemming from years of having witnessed her father physically abusing her mother. Many other women also talked about children with specific, severe, and chronic problems that were still being monitored and would likely require surgical intervention and additional medical care at some point in the future:

> *She's got an enlarged kidney. . . . It just growed like that, but that tube that runs from the bladder to the kidney, it blocks, and the urine lays into the kidney and it keeps causing her infections all the time. . . . They don't know what if they're gonna do in there and replace the tube or whatever, I don't know what they're gonna do. But the tests were hard for her.* Barbara, Cleveland

> *He's sick. He has intestinal problems. He can't have normal bowel movements. Everything just stays inside, and so, once he's filled up, I have to take him to the doctor. To the hospital, and he stays in, for like a week, and then they clean him out. Um, recently, he had surgery, but apparently the surgery didn't work. . . . He's been sick for five whole years. . . . He's 6. He hasn't attended school yet either. Because of the fact that he has to be in and out of the hospital. . . . Um, yeah, he was diagnosed with autism. And this wasn't even known until this year.* Norma, Los Angeles

> *. . . 'cause his leg got a tumor [referring to a young child who also has very severe asthma], in this one leg, and eventually, one day, they're gonna have to take it out. . . . And, when they do, he's gonna be, um, he'll probably be disabled from that . . . 'cause he's not gonna have no muscle tone left in his leg . . . it goes from his calf all the way to underneath his butt.* Maria, Cleveland

Whether they were talking about minor colds or the need to care for severely disabled children, many women noted that caring for sick children might make it difficult (or, in some cases, had already made it difficult) for them to enter or sustain work. Here is how some women described their dilemma:

---

[9] This woman told the interviewer: "I would have to disarm him when the courts made me let him see his father. I would have — I took seven butcher's knives off him once. He was 7 years old. He wanted to kill his father. He told me how he would do it and why he could get away with it."

> *I'm afraid to try it [going to work]. . . . If my, you know, if my daughter's sick, what do I do? If they need to go to the doctor, what do I do?* Michelle, Los Angeles
>
> [Mother of an asthmatic child:] *I'd like a job that at least allowed me to check on my daughter. . . . You know, there are jobs that if you miss a single day, they'll fire you.* Rosario, Miami
>
> [Mother of a daughter with cancer:] *I would prefer to work twenty times over, but with my daughter's disease, they told me I should stay with her. . . . Now I have to be at her side, but I would also like to work because it's the only way we can subsist.* Carmen, Miami
>
> *My one daughter, she had almost 105° fever and she was throwing up and I couldn't get nobody to cover for me, and her face was red and she was crying on the phone saying she didn't feel good, and I had, like, two hours to go, and I couldn't get no one to cover for me. And I told her to lie on the couch and just keep calling me. And then my son, he called and said, "Mom, she is throwing up all over the carpet" . . . he started getting scared because she was turning red. . . . So I didn't have a choice. I had to finish work and then I had to take her over to the hospital.* Eileen, Philadelphia

Having multiple children with health problems can exacerbate the difficulty of working. One woman in Los Angeles had a "very misbehaving" 14-year-old daughter who had been badly beaten by her boyfriend, a school-age child with ADHD, and a younger child with severe asthma:

> *And then I had to take the youngest boy to the hospital three times. He has asthma and he got a really bad cough. . . . So, I can't have a stable job right now because of the youngest boy. . . . Right now, this week, he got sick again, but it was not as bad as the last time . . . it lasted about two or three days. But sometimes, it lasted for about six days.* Angela, Los Angeles

Several women in the ethnographic sample indicated that they had left work for welfare in order to care for ill children:

> *Then after I had my second child, I went to work, but I had to quit because she got sick and had to go into the hospital twice. . . . But like I told them, when I went and told them that I had to quit my job, my kids are more important than the job. . . . I'm not gonna leave my kids in the hospital by themselves. . . . If you can't understand at my job that my kids come first, and that I will be back, then either fire me or I quit. And my kids is my number one priority.* Margaret, Cleveland
>
> [Mother whose daughter had a severe seizure disorder:] *So, being that she was so sick, and I, at the time, I was working at the Federal Reserve Bank, to try to make ends meet after my father passed. She, she was just too sick. I had to stop work-*

> *ing, really, you know, get her to the doctors and everything, because she was constantly seizing.* Tasha, Cleveland

> [Interviewer:] *Are you currently employed?*
> [Respondent:] *No, I'm not. I used to be employed, like in early November, but I got, um, he fired me because my daughter had had a asthma attack and that night I had to go into work. And that was her first asthma attack and I couldn't make it in, so he fired me.* Geraldine, Cleveland

Some women also noted their difficulty in juggling their children's health care needs with participation in welfare-mandated work-related activities like job club:

> *[They'll sanction you] if you don't do their assignment . . . going and looking for a job, doing a job search, going to the . . . program that I'm in now. The rules are real strict for that. Say, like, me, I have two kids with asthma. If one of them get sick, I'm not supposed to miss that day. I'm supposed to go to school and let them know, and then if it's OK with the teacher — for her to send me home. I'm like, "No! Not me!"* Renee, Miami

> *Look, a few days ago, my son woke up with one of his eyes swollen and inflamed. I got an appointment at the clinic . . . I myself wasn't feeling well. I have a bad cold, but still I had to go down there to [the welfare agency]. One has to go every day.* Juliana, Miami

This second mother went to the clinic but was told she had to get on a waiting list. After waiting several hours, she had to leave the clinic, with her son untreated, to go to job club.

Although most mothers with ill or special-needs children indicated that they would not be able to balance work and caring for their children, a few women thought it could be managed. These women typically had husbands or supportive family members who could be counted on for assistance. One woman in Miami, whose daughter had asthma (as well as sores from head lice) and whose son had sickle cell anemia, said that if she worked, her mother would take care of her children. As another example, a woman from Cleveland with a mildly retarded daughter who had motor coordination problems said:

> *Well, she probably never would be here alone. The way I work it out is if I take a job anywhere, I'm going to work it out so that, like, I'd be home just about when school's out or something, so I would be home. Or my husband would be here or something, because I don't like her to be totally alone for a long period of time.* Kathy, Cleveland

Another strategy that some women mentioned for combining child care and work involved finding a way to work at home. The woman noted above who had a daughter with a severe seizure disorder indicated that she would like to work at home so that she could be there to get her daughter off the bus or to take care of her child if she were unable to go to school.

In summary, a substantial number of women in the ethnographic sample had one or more children with health problems, and some of these problems were quite serious. Most of these mothers were concerned about their ability to work and still have the time and flexibility to tend to their children's health care needs.

III. Children's Health Insurance

Children's Health Insurance: Highlights of the Findings

- About 17 percent of the women in the Urban Change survey sample had at least one child without health insurance in the prior month.
- Children whose mothers received welfare were substantially more likely to be insured than children of former recipients.
- Public insurance (especially Medicaid) was the most common form of insurance for children in all four work/welfare groups, including children of women in the work-only group.

As noted in Chapter 6, the percentage of uninsured Americans has been increasing over the past decade. Despite Medicaid expansions during the early 1990s that extended eligibility to low-income children not on welfare, the percentages of uninsured children also grew between 1989 and 1998. In 1989, some 13.3 percent of all children under age 18 were uninsured (25.0 percent of all children below the federal poverty level); in 1998 — the most recent year for which Census Bureau data are available — 15.4 percent of all children (25.2 percent of those in poverty) lacked health insurance. Thus, in 1998, some 11.1 million American children were uninsured and therefore at heightened risk of preventable health problems (U.S. Bureau of the Census, 1999b; U.S. General Accounting Office, 1995).

In response to this situation, Congress established the Children's Health Insurance Program (CHIP)[10] in the Balanced Budget Act of 1997. The CHIP block grant provides states with funds to implement expanded health insurance coverage for uninsured children whose families do not qualify for Medicaid but cannot afford private health insurance. By January 2000, all states had an approved CHIP plan in place, and as of September 30, 1999, nearly 2 million children had enrolled. Moreover, one of the goals of CHIP is to identify and enroll children who are Medicaid-eligible and not enrolled, and preliminary state reports indicate that CHIP outreach has led to higher enrollment of Medicaid-eligible children (Health Care Finance Administration, 2000).

Because the Urban Change survey data were collected primarily in 1998, when the CHIP program was in its infancy, it was expected that there would be a strong relationship between children's health insurance status and their mothers' work/welfare status. This hypothesis is consistent with the evidence indicating that women lose health insurance coverage for themselves and their children when they leave welfare (Moffitt and Slade, 1997; Coulton et al., 2000); that

---

[10] This program is sometimes referred to as the State Children's Health Insurance Program, or SCHIP.

Medicaid is a major incentive for staying on welfare, especially among parents whose children have significant health problems (Moffitt and Wolfe, 1992; Wolfe and Hill, 1995); and that children's health problems are a deterrent to mothers' employment (Salkever, 1982). Specifically, then, it was predicted that children of women who still received welfare at the time of the Urban Change survey interview would be more likely to have health insurance — and to have adequate health care access — than children of welfare leavers.

Chapter 6 indicated that about 20 percent of the women in the Urban Change sample were uninsured in the month prior to the interview. A similar, but lower, percentage of mothers — 16.5 percent — had at least one child without insurance (see Table 7.2). The insurance coverage pattern across the four work/welfare groups was similar for children and their mothers: Children whose mothers received welfare were substantially more likely to have health insurance than children whose mothers had left welfare — especially if those mothers were not working.

Younger focal children were less likely than older ones to be uninsured in the prior month, consistent with national data (U.S. Bureau of the Census, 1999b). Some 11.0 percent of the preschool-age focal children were uninsured, compared with 15.6 percent of the adolescent focal children. In both cases, the rates of uninsurance were somewhat lower than the rate nationally for poor children in 1998 (15.5 percent for children under 6 and 16.0 percent for children age 12-17), presumably reflecting the high rate of welfare and Medicaid receipt in the Urban Change sample — but also likely reflecting differences in the reference period for insurance status (that is, a point-in-time estimate in Urban Change versus coverage in an entire year in the Current Population Survey).[11] For both sets of focal children, rates of uninsurance were highest among the children of former recipients — especially those in the no-work, no-welfare group. For example, older focal children of women who neither worked nor got welfare were *seven* times more likely than adolescents in the welfare-only group to have been uninsured in the month prior to the interview (33.1 percent versus 4.7 percent, respectively).

Focal children whose mothers had left welfare were also more likely than those whose mothers were still recipients to have been uninsured at some point in the previous year. Overall, 17.7 percent of the preschoolers and 19.2 percent of the adolescents had gone without health care coverage at some point in the prior year. About one-third of the older focal children whose mothers no longer received welfare had had a spell of uninsurance in the prior year, compared with less than 10 percent for those in the two groups of current welfare recipients.

---

[11] The U.S. Bureau of the Census' Current Population Survey asks about health insurance in an entire year, and point-in-time estimates would be expected to be lower. Another national survey (the Community Tracking Study) does obtain point-in-time estimates. At the time of this 1996-1997 survey, some 11.7 percent of children under age 18 were uninsured (Center for Studying Health System Change, 1998), a rate similar to that in Urban Change.

The Project on Devolution and Urban Change

Table 7.2

Children's Health Insurance Status, by Mother's Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Any child uninsured, prior month	16.5 ***	27.8	6.8	6.7	34.5
Younger focal child, prior month[b]					
No health insurance	11.0 ***	19.6	3.5	3.8	31.3
Covered by mother's employer	12.9 ***	33.6	5.0	1.8	10.9
Covered by other private insurance	3.1 ***	6.9	1.5	1.2	2.4
Covered by Medicaid	70.0 ***	40.1	86.4	87.3	57.2
Covered by CHIP	4.6	5.3	3.8	5.1	1.8
Past 12 months					
Ever uninsured	17.7 ***	29.4	9.1	9.8	31.7
Older focal child, prior month[c]					
No health insurance	15.6 ***	30.4	5.5	4.7	33.1
Covered by mother's employer	11.1 ***	30.0	4.0	1.2	9.6
Covered by other private insurance	3.3 ***	5.4	3.3	0.9	6.7
Covered by Medicaid	66.7 ***	34.2	85.6	86.5	48.9
Covered by CHIP	5.2	5.2	5.9	5.4	3.4
Past 12 months					
Ever uninsured	19.2 ***	34.3	8.8	9.4	32.0
Sample size	3,610	1,178	617	1,438	377

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

All child outcomes utilize maternal reports.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Younger focal children were selected from those children in the household age 6 or younger.

[c] Older focal children were selected from those children in the household between ages 12 and 18.

Among those focal children *with* insurance, public insurance was substantially more prevalent than private insurance. About two-thirds of the focal children in both age groups had Medicaid coverage in the prior month, and about 5 percent had participated in their state's CHIP program, which had only recently been implemented when the survey was fielded.[12] The vast majority of focal children in current welfare families had Medicaid coverage, but even in the two welfare leaver groups, Medicaid was the most common type of insurance. For example, as shown in Table 7.2, 40.1 percent of preschoolers in the work-only group and a full 57.2 percent of those in the no-work, no-welfare group had Medicaid coverage in the prior month,[13] indicating that at least some mothers knew and were taking advantage of the fact that Medicaid eligibility was not linked to welfare receipt.

Employer-provided health insurance was available to just over 10 percent of the focal children in both age groups and was obviously more common among children whose mothers were working. One-third of the children in the work-only group, compared with only about 5 percent of those in the work-and-welfare group, had insurance through employers. The groups also differed with regard to other private insurance, which covered 3.1 percent of all younger focal children and 3.3 percent of all older focal children.

In summary, in the survey sample, the Urban Change mothers' source of income was powerfully related to their children's health insurance status. All these group differences relating to children's insurance remained statistically significant even after controlling both the mothers' background characteristics and their total family income.

In the ethnographic sample, all the women were receiving cash assistance at the time of the baseline interviews, and thus both they and their children were eligible for Medicaid. As discussed in Chapter 6, many women said they had gone on welfare to obtain health insurance, and many expressed concern about losing health insurance when they went to work. Concerns about welfare and insurance often implicitly related to both their own and their children's health insurance coverage, but some mothers specifically expressed anxiety about their children losing health insurance if the women were unable to comply with new welfare regulations or if they went to work. Here are some examples of how women expressed their concerns:

> [Woman with two severely disabled children:] *I went, periodically, went off [welfare], but my kids were really sickly and I needed the medical for them. Between my five kids, they've been in the hospital 35 times.* Olivia, Cleveland
>
> [Woman whose daughter had a severe seizure disorder:] *Oh, dear. I'm not too concerned about the actual cash. Not that who doesn't need money. My concern will be with the food stamps and the medical. That would devastate me and my situation.* Tasha, Cleveland

---

[12] Nationally, 15.1 percent of children under age 18 were covered by Medicaid at the time of the 1996-1997 Community Tracking Study survey; 70.0 percent of children nationally were covered by private insurance.

[13] Approximately 12 percent of children in the two nonwelfare groups had Medicaid in the prior month, while their mothers did *not* have Medicaid coverage.

> [Woman whose son was born with a severe physical disability:] *I would lose, which is very important, which I can't lose, is the children's Medicaid. I can't pay it [health insurance].* Mariela, Miami

> [Woman with a child who had heart problems:] *Running out of food stamps, the cash, it doesn't even really concern me. I mean, it does, it would help but, at the same time . . . the well-being of my children. I'm not financially able to give them the health care that they need.* Kelly, Philadelphia

Women's worries about their children losing health insurance reflected, in part, inadequate understanding of the rules of noncash Medicaid benefits and the CHIP program, which was still relatively new at the time these baseline interviews were conducted. CHIP (or the state equivalent) was not often mentioned in the baseline interviews. One respondent who knew something about the program spoke of it this way:

> *. . . 'cause of the Chap or some like that. C-H-I, don't remember the name, but some doctors offer the, if you don't have Medi-Cal, they have that program, if you're low income . . . I don't remember the name of it. But, it also goes with the medical something. It's under [age] 18, and, you don't have Medi-Cal, you know, like for physical, you'll get it and it's free. If you have low income.* Myrna, Los Angeles

In summary, health insurance for their children — especially among mothers whose children had chronic and ongoing health problems — played an important role in the women's thinking about employment and welfare.

IV. Children's Health Care Utilization

Children's Health Care Utilization: Highlights of the Findings

- Among the Urban Change survey sample, some 4 percent of preschool-age focal children, and 16 percent of adolescent focal children, had not seen a doctor for routine health care in the prior year.
- More than one-fourth of the younger and older focal children had not obtained dental care in the previous year.
- Children of mothers who did not receive welfare were substantially more likely to have forgone both routine health care and dental care.

Table 7.3 shows that about one out of seven mothers in the Urban Change survey sample had a child who had been hospitalized at some point in the year prior to the interview.[14] In the Urban Change sample, children in the four work/welfare groups had similar rates of hospitalization. Children who had been hospitalized were, on average, 7.2 years old at the time of the interview (not shown).

Mothers were also asked if their focal children had received routine medical and dental care in the previous 12 months. In the Urban Change sample, only a small minority of the preschoolers (4.4 percent) had failed to visit a doctor for a routine checkup, but there were noteworthy group differences. Nearly one out of ten of the children in the no-work, no-welfare group, compared with only 3-4 percent of the children of current welfare recipients, had forgone routine medical care in the previous year.

Prior studies have demonstrated that dental care is one of the greatest unmet health care needs among poor children (see, for example, Waldman, 1998; Vargas et al., 1998). Some 27.1 percent of the younger focal children had not seen a dentist in the previous 12 months, and about half of these (13.3 percent) had never seen a dentist.[15] The group differences for both these indicators of dental care utilization were not statistically significant.

Rates of not having obtained routine medical and dental care were somewhat higher among the older focal children than among younger ones. Some 15.9 percent of the adolescents had not been to see a doctor for routine care in the prior year, and 4.4 percent had not seen a doctor in over two years (not shown). Nearly one-third of the adolescents had not seen a dentist in the prior year. About 10 percent had not seen one in more than two years (not shown), and 1 percent had never seen a dentist. Children of women no longer on welfare were less likely than the adolescent children of recipient mothers to have obtained routine dental care. Additionally, adolescent children in the two former recipient groups were less likely to have seen a doctor or therapist for an emotional problem in the past 12 months.[16] Whether this difference reflects greater unmet need or differences in the prevalence of emotional problems cannot be determined from these data. Finally, 26.1 percent of the adolescents wore corrective eyeglasses or contact lenses at the time of the interview, and an additional 10.5 percent reportedly needed eyeglasses but did not wear them. The four groups were similar on these two indicators.

---

[14] Some 1.9 percent of the preschool-age focal children and 4.3 percent of the adolescent focal children had had a hospital stay in the prior 12 months. By comparison, 2.0 percent of children age 5-17 nationally were hospitalized in 1996 (National Center for Health Statistics, 1999).

[15] The average age of the focal children who did not see a dentist in the previous 12 months was 4.3 years, and the average age of those who had never seen a dentist was 3.8 years. The American Dental Association recommends that children have a dental examination by the age of 1 (American Dental Association Web site).

[16] The group differences for adolescents' health care utilization variables were no longer statistically significant when mothers' background characteristics were controlled.

The Project on Devolution and Urban Change

Table 7.3

Children's Health Care Utilization, by Mother's Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Any child hospitalized, past 12 months	14.1	12.0	14.9	14.9	16.3
Younger focal child, past 12 months[b]					
Not seen doctor for routine care	4.4 *	4.8	2.9	3.8	9.0
Not seen dentist	27.1	29.6	23.1	27.3	26.9
Never seen dentist	13.3	13.9	12.7	13.0	13.8
Older focal child, past 12 months[c]					
Not seen doctor for routine care	15.9	18.5	14.7	13.8	18.4
Not seen dentist	30.5 *	35.4	28.3	28.0	30.3
Has seen therapist about an emotional problem	9.4 *	6.1	12.9	10.3	9.5
Wears eyeglasses	26.1	27.3	28.3	23.8	29.1
Needs eyeglasses but does not wear them	10.5	12.1	9.7	9.7	10.7
Never seen dentist	1.1	1.1	0.7	1.2	1.7
Sample size	3,735	1,232	623	1,456	424

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

All child outcomes utilize maternal reports.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant except "Younger focal child not seen doctor for routine care." The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Younger focal children were selected from those children in the household age 6 or younger.

[c] Older focal children were selected from those children in the household between ages 12 and 18.

Women in the Urban Change ethnographic sample were not asked explicit questions about children's health services utilization, with the exception of questions that inquired about whether any of their children had not received needed medical or dental care because the mother could not afford it. Because virtually all their children were covered by health insurance, women rarely mentioned having children with unmet needs for medical or dental care. The two exceptions were that (1) some women reported that they had difficulty paying for certain prescriptions or over-the-counter medications that were not covered by insurance and that (2) others expressed concerns that Medicaid would not pay for certain types of dental care, such as braces.

The only other issue that emerged relating to children's health care utilization in the ethnographic interviews was the concern that some women expressed about juggling employment with well-child care, as in the following excerpt from a mother who worked:

> *Like Monday, I have to worry about that Monday, because I'm off like on a weekend and no clinic isn't open on a weekend. I get off at 5:00 P.M., around that time they're closed. So, I'm going to have to make special arrangements on the job for Monday for he has to get his shots in order for him to be healthy.* Coleen, Miami

V. Children's Health and Health Insurance

Children's Health Insurance and Health Outcomes: Highlights of the Findings

- Among the Urban Change survey sample, children who were in poor health were as likely *not* to have health insurance as to have it.
- For both older and younger focal children, those without health insurance had a higher likelihood of having forgone routine medical and dental care.
- Adolescents without health insurance were significantly more likely than those with insurance to need eyeglasses but not have them.

As noted earlier, it has repeatedly been found that health insurance improves children's access to care. Table 7.4 examines selected health and health care outcomes for younger and older focal children in relation to whether or not they had health insurance coverage in the month before the interview.[17] For the younger focal children, there were no significant relationships between having health insurance, on the one hand, and having an illness or disability, being in fair or poor health, or having had an accident in the prior year, on the other hand. This means, of course, that as high a proportion of preschoolers with health problems were uninsured as were insured, and thus they were more at risk of having unmet needs for care.

---

[17] The outcomes in Table 7.4 were also examined in relation to whether the focal children had been uninsured *at any point* in the previous 12 months. The pattern of results was virtually identical to those shown in the table.

The Project on Devolution and Urban Change

Table 7.4

Selected Health Outcomes for Focal Children, by Health Insurance Status in Prior Month

Outcome (%)	Younger Focal Child[a]		Older Focal Child[b]	
	Insured	Uninsured	Insured	Uninsured
Has an illness/disability that limits mother's work or school participation	10.1	7.3	10.7	5.9 *
Rated in fair to poor health	7.9	6.8	11.6	12.5
Past 12 months				
Not seen doctor for routine care	3.4	12.1 ***	12.8	32.5 ***
Not seen dentist	25.0	43.4 ***	26.1	54.2 ***
Has seen therapist about an emotional problem	n/a	n/a	9.8	7.4
Had an accident or injury requiring medical attention	9.1	9.2	8.9	8.6
Needs eyeglasses but does not wear them	n/a	n/a	9.8	14.2 *
Sample size	562	340	768	179

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

All child outcomes utilize maternal reports.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

N/a = not applicable.

[a]Younger focal children were selected from those children in the household age 6 or younger.

[b]Older focal children were selected from those children in the household between ages 12 and 18.

Among preschoolers, health care utilization was significantly related to the children's insurance status, a pattern similar to that observed for their mothers. Nearly four times as many preschoolers without health insurance (12.1 percent) as those with insurance (3.4 percent) had not obtained routine medical care in the prior year. And 43.4 percent of the younger uninsured children had not been to see a dentist in the prior year, compared with 25.0 percent of the insured children.

Adolescents who had an illness or disability that limited their mother's participation in school or work were significantly more likely to have insurance than not, but even then about 6 percent of the uninsured adolescents had such a disability, and nearly one out of seven adolescents without insurance (11.6 percent) was in fair or poor health. As was true for the preschool-age focal children, adolescents' health care utilization was linked to their insurance status. One-third of the uninsured adolescents had not seen a doctor for routine care in the prior year, compared with only 12.8 percent of those with insurance. And twice as many of the uninsured (54.2 percent) as insured adolescents (26.1 percent) had not received dental care in the previous 12 months. (For both younger and older focal children, the differences in recent medical and dental care by insurance status remained statistically significant when family income and maternal background variables were controlled.) Finally, significantly more of the uninsured older children than the insured ones needed glasses but didn't wear them (14.2 percent versus 9.8 percent, respectively). Insurance status was unrelated to whether or not the adolescents had been treated by a therapist for an emotional problem in the prior year.

In summary, a number of children in the sample suffered from health problems without having insurance coverage, and insurance was strongly related to whether or not these children were getting medical and dental attention.

VI. Discussion

Overall, the children in the Urban Change sample were substantially less healthy than children nationally. These children were more likely than children in national surveys to have an activity-limiting health condition, to be rated in fair or poor health, and to have had a hospital stay in the prior year. Fully one out of five Urban Change mothers said that she had a child with an illness or disability that made it difficult for her to work or go to school. The ethnographic data provide rich insights into the magnitude of such burdens.

The findings for children's health outcomes in relation to income source were remarkably similar to the findings for their mothers. Children of mothers who did not work were less healthy than children of working mothers — just as nonworking women had more health problems than working ones. The group differences in the mothers' constraints on employment stemming from a child's illness or disability remained statistically significant even after controlling for the family's income; this — together with findings from the ethnographic data — lends support to the interpretation that the mothers' employment behavior was affected by their children's health problems rather than being spuriously correlated as a result of differences in financial resources. Women may be constrained from entering the labor force because of the demands of their children's illnesses, and employed women with sick or disabled children often face difficult choices about caring for their children's needs. For example, fewer than half the women in the Urban

Change sample who were working had jobs that provided sick leave (see Table 2.5) — time off that may be needed for them to manage their children's health care without incurring the risk of dismissal.

It should be remembered that the children in the four work/welfare groups also differed in terms of other factors that are health-related, as discussed in previous chapters. The children in the two nonworking groups were living in the poorest households, with mothers who themselves were especially likely to be struggling with health problems and material hardships. Children of nonworking mothers were more likely than children whose mothers worked to be living in families with food insecurity and worst-case housing needs and to have mothers who had been homeless or sheltered in the previous year (Chapter 3). Compared with children in the two working groups, those in the two nonworking groups also had mothers who were less healthy (Chapter 4) and at higher risk of depression (Chapter 5), which has repeatedly been found to be associated with negative child outcomes. Thus, the children and their mothers in the nonworking groups were especially likely to be exposed to conditions that posed threats to their health and well-being — and to conditions that might create obstacles to maternal employment.

Children's health care access, like access for their mothers, was a function of their mothers' welfare status more than their mothers' employment. Children whose mothers had left welfare were substantially less likely to be insured and were also less likely to have obtained routine medical and dental care in the prior year. Insurance status was strongly related to the children's health care utilization. Many uninsured children in the sample had forgone routine care and had health conditions that made health care and treatment essential.

Children whose mothers neither worked nor received welfare appear to have had particularly acute health vulnerabilities. Similar to the situations experienced by their mothers, these children were among the least healthy — and were also the least likely to have had health care coverage.

Chapter 8

Multiple Health and Nonhealth Problems

I. Multiple Barriers to Employment

Multiple Barriers to Employment: Highlights of the Findings

- Among the Urban Change survey sample, the majority of women (72.7 percent) had at least one health problem (out of eight considered) that could be a barrier to employment.
- The majority of women in all four work/welfare groups had a potential health barrier, but women in the work-only group were least likely to have one.
- About half the women in the two nonworking groups had two or more health problems that could constrain employment.

A. Multiple Barriers in the Overall Urban Change Sample

As discussed in Chapters 4 and 5, women in the Urban Change survey and ethnographic samples often had co-occurring health and mental health problems. To better understand constraints to employment, a number of researchers have begun to create multiple barrier scales to describe the circumstances of poor women. For example, Quint, Fink, and Rowser (1991), using information from program staff in a national demonstration of a comprehensive program (New Chance) for teenage mothers on welfare, reported that 74 percent of the young women they rated had one of ten problems and that the majority of those with a problem had multiple problems. (Notably, unlike other studies focused on multiple barriers, the New Chance results were based not on self-reports but rather on the observations of staff who had an ongoing relationship with the women studied.) Olson and Pavetti (1996), using data from the National Longitudinal Survey of Youth (NLSY), found that 89.1 percent of the women receiving welfare in 1991, compared with 55.9 percent of those not receiving welfare, had at least one potential barrier to employment, out of six specific barriers (a health limitation, children's health problems, depression, alcohol abuse, drug use, and very low scores on a test of basic skills). About half the recipients in this national sample had two or more such barriers. Zedlewski (1999), using data from the 1997 National Survey of America's Families, found that over 40 percent of welfare recipients reported two or more obstacles to work, including both health and nonhealth obstacles. Speiglman, Fujiwara, Norris, and Green (1999) developed a multiple barrier index composed completely of health-related barriers and found that about two-thirds of welfare recipients in Alameda County (California) had one potential health barrier or more. Most recently, Danziger et al. (2000) developed a multiple barrier index composed of 14 barriers, including several health and mental health problems. They also found that almost two-thirds of their 1997 sample of welfare recipients in an urban Michigan county had two barriers or more and that over one-fourth had four or more.

An index of *multiple potential health barriers*[1] was created in the present study using eight health indicators: having an unfavorable score on the physical component of the SF-12 scale, being at moderate or high risk of depression, having more than five doctor visits in the prior year,[2] being morbidly obese, having been homeless or sheltered in the prior year, having been physically abused in the prior year, having used a hard drug (cocaine, heroin) in the prior month, and caring for a child with an illness or disability that affected the mother's employment.[3] The indicators were selected for the multiple health barrier index based, in part, on their correlations with a criterion — the woman's assertion that she had a health problem that made it difficult for her to work.[4] Table 8.1 lists the eight health barriers included in the index and indicates the prevalence of each in the overall Urban Change survey sample. As Figure 8.1 shows, fully 72.7 percent of the women had at least one of these health barriers. More than two out of five women (41.4 percent) had multiple health impediments. On average, women faced 1.4 potential health barriers to employment.

The health problems of these women were often compounded by other impediments that presumably pose additional challenges to finding and keeping a job. A separate index of non-health-related barriers was constructed, using five indicators: not having a high school diploma or General Educational Development (GED) certificate, never having worked for pay, not being able to converse in English, having three children or more; and having a child under age 3. These are characteristics (shown in Table 8.1 with prevalence rates in the Urban Change sample) that have been shown not only to deter exits from welfare but also to increase the likelihood of returning to welfare after an exit due to employment (Harris, 1996).[5] Some 72.6 percent of the sample had at least one of these five impediments, and 14.1 percent had three or more (not shown).

Taking the two indexes together — the multiple health barrier and the multiple nonhealth barrier indexes — *only 9.1 percent of the sample faced* none *of the 13 constraints*. In comparison, 15 percent of the welfare recipients from a random sample of welfare recipients in an urban Michi-

---

[1] Health problems are not *necessarily* barriers to employment (that is, some women with health problems *do* work) but, rather, are *potential* barriers. For simplicity sake, and for the sake of consistency with other studies, the term "multiple barriers" is used in this report in lieu of the more cumbersome but more accurate term, "multiple potential barriers."

[2] On average, U.S. women age 18-44 in 1996 had 4.7 office or clinic visits with physicians in the prior year (National Health Interview Survey data).

[3] As explained in Chapters 4 and 5, for the physical component of the SF-12, a score below 40 (one standard deviation below the national norm) was considered a barrier; for the CES-D (depression) scale, a score of 16 or higher was counted as a barrier; and a person was classified as morbidly obese if her body mass index (BMI) exceeded 40.

[4] Other health indicators that were considered for inclusion were alcohol abuse, food insecurity, having three or more material hardships, smoking status, and self-rating of being in fair- or poor health. These were generally correlated with the criterion, but at lower levels — or they were not included because of redundancy with other indicators.

[5] It is important to note that both the Urban Change ethnographic data and the findings from other studies indicate that this population faces many other impediments to employment, most of which were not measured in the survey. These include not having a telephone, having responsibility for the care of sick family members other than one's own children, problems finding stable child care, having a criminal record, having a learning disability, having a partner or other family member who undermines self-sufficiency efforts, lack of self-confidence, and concerns about (or experiences with) racial or gender discrimination.

The Project on Devolution and Urban Change

Table 8.1

Prevalence of Health[a] and Nonhealth[b] Barriers to Employment

Barrier (%)	Percentage in Sample with Barrier
Health barriers[a]	
Score of less than 40, physical component of SF-12[c]	31.2
At moderate or high risk of depression[d]	49.9
Had more than 5 doctor visits in past 12 months	28.9
Morbidly obese (BMI greater than 40)[e]	7.1
Homeless or sheltered in past 12 months	2.5
Physically abused in past 12 months[f]	8.8
Use of heroin, cocaine, or crack	2.5
Has 1 child or more with an illness/disability affecting mother's ability to work	19.8
Nonhealth barriers[b]	
No high school diploma or GED	45.8
No paid work experience	8.0
Unable to converse in English	7.9
Has 3 or more children	41.7
Has a child under age 3	22.2

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

Table 8.1 (continued)

[a] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

[b] Nonhealth barriers include: no high school diploma or GED, no paid work experience, unable to converse in English, has three children or more, and has a child under age 3.

[c] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[d] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

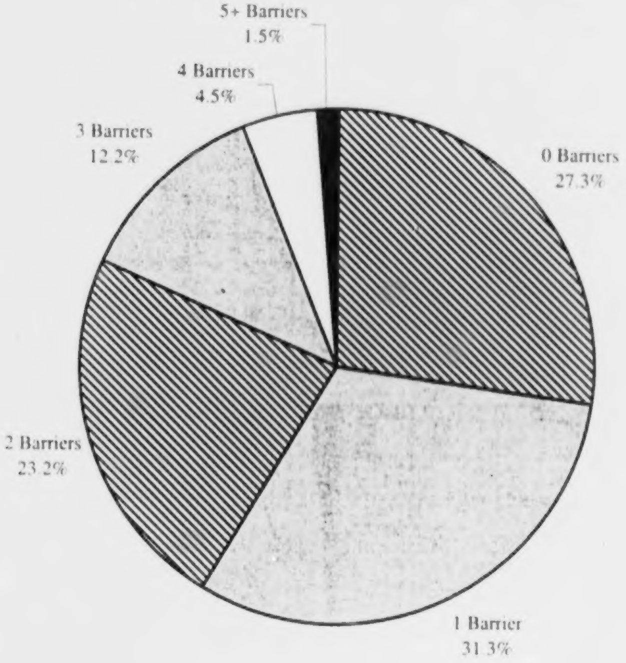
[e] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

[f] The respondent reported that she was hit, slapped, or kicked.

The Project on Devolution and Urban Change

Figure 8.1

Prevalence of Health Barriers,[a] Urban Change Respondent Survey Sample



SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE:

[a]Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

gan county had none of the 14 included barriers (Danziger et al., 2000),[6] and 23 percent of the TANF recipients in the 1997 National Survey of America's Families (NSAF) had none of the 7 barriers considered (Zedlewski, 1999). In the Urban Change survey sample, fully three times as many women had four barriers or more as had none (29.6 percent versus 9.1 percent, respectively). It should be noted that in the Urban Change study the two multiple barrier scales were correlated: Women with multiple health barriers tended also to have multiple nonhealth barriers. For example, 23.2 percent of the women with three or more structural and human capital barriers — compared with only 14.8 percent of women with none — also had three or more health barriers.[7]

B. Multiple Barriers in the Four Work/Welfare Groups

Given the fact that women in the work-only group had invariably better health and mental health outcomes than women in the other three groups, as discussed in earlier chapters, it was expected that fewer of them would face multiple health impediments. This expectation is also consistent with other work on multiple barriers. Olson and Pavetti (1996) found in their NLSY sample that recipients without any of the barriers in their multiple barrier index were significantly more likely to have recent work experience than recipients with moderate and severe barriers; for example, among recipients with at least one of the six barriers, 59 percent had worked in the current or previous year, compared with 68 percent without a barrier. In the 1997 NSAF, work activity among recipients declined steadily with increasing employment barriers (Zedlewski, 1999). Danziger et al. (2000) found that the greater the number of barriers among urban welfare recipients, the lower the likelihood that they would be working. For example, the probability of working 20 hours or more per week was 82.1 for women with no barriers, compared with 40.0 for those with 4 to 6 of the 14 barriers on their scale. Cancian, Haveman, Meyer, and Wolfe (2000), in a recent study in Wisconsin, found that the likelihood of consistent employment in the year after a welfare exit was significantly higher among high-barrier women than among low-barrier women.

As expected, women in the work-only group in the Urban Change survey sample were less likely to have not only individual health problems but also multiple health problems. As shown in Table 8.2, the majority of women in all four groups had at least one health problem, but women in the work-only group were least likely to have such a barrier (60.0 percent), and women in the welfare-only group were most likely to have at least one (82.4 percent). More than half the nonworking welfare recipients (54.3 percent) had two or more health problems, and women in the no-work, no-welfare group also had a high rate of multiple health barriers (46.0 percent). On average, women in the welfare-only group had nearly twice as many health barriers (1.8) as did women in the work-only group (1.0).

Women in the work-only group also had the fewest structural and human capital barriers (see Chapter 2), such as low educational attainment. Table 8.2 shows a pattern similar to that observed for the health barriers. Former recipients who were working had significantly fewer nonhealth barriers

---

[6] There is considerable overlap between the 13 Urban Change barriers and the 14 barriers in the Danziger et al. study: for example, education credentials, work experience, drug use, depression, health problem, child with a health problem, and domestic violence.

[7] In the correlation matrix using all 13 barriers, the highest correlation was between having an unfavorable score on the physical component of the SF-12 and having multiple doctor visits ($r = .25$). Out of 78 bivariate correlations, only 6 (8 percent) exceeded .15.

Table 8.2

Multiple Potential Barriers to Employment, by Work and Welfare Status[a]

Characteristic (%)	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Health barriers[b]						
Mean	1.4	***	1.0	1.3	1.8	1.5
None	27.3	***	40.1	27.0	17.6	23.3
1	31.3		33.8	34.1	28.1	30.7
2 or more	41.4		26.2	38.9	54.3	46.0
Nonhealth barriers[c]						
Mean	1.3	***	0.9	1.3	1.6	1.3
None	27.4	***	42.0	22.9	18.1	24.7
1	34.9		35.5	36.3	33.3	36.4
2 or more	37.8		22.5	40.8	48.7	38.8
Health and nonhealth barriers						
Mean	2.7	***	1.8	2.6	3.3	2.9
None	9.1	***	18.3	7.5	3.4	4.2
1	18.7		28.5	17.8	11.6	15.9
2-3	42.5		39.7	47.9	40.8	48.5
4-5	23.5		11.9	23.7	32.8	25.9
6 or more	6.1		1.6	3.2	11.4	5.5
Sample size	3,591		1,172	615	1,428	376

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

Table 8.2 (continued)

[b] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

[c] Nonhealth barriers include: no high school diploma or GED, no paid work experience, unable to converse in English, has three children or more, and has a child under age 3.

than women in other groups, and particularly fewer than current recipients who were not working. For example, 42.0 percent of the women in the work-only group, compared with 18.1 percent of those in the welfare-only group, had none of the five structural and human capital barriers.

It is therefore not surprising that employed welfare leavers had the fewest of the combined health and nonhealth barriers. Nearly half of them (46.8 percent) faced no more than one of the 13 barriers on this index. In sharp contrast, among women in the welfare-only group, a similar proportion (44.2 percent) faced *4 or more* of these barriers, and only a small minority (3.4 percent) had none of the potential barriers to employment. Women in the no-work, no-welfare group also had a high rate of multiple barriers, with nearly a third (31.4 percent) reporting four impediments of more. The majority of women who combined work and welfare also had multiple barriers, but they had fewer health problems than women who were not working.

II. Employment Enablers in the Face of Multiple Health Problems

Employment Enablers: Highlights of the Findings

- Despite multiple health barriers, some women in the Urban Change survey sample *were* able to work: About 26 percent in the work-only group and nearly 40 percent in the work-and-welfare group had multiple barriers.
- Working women with multiple barriers — especially welfare leavers — were more likely than nonworking women to have enabling characteristics (for example, college credits, good social skills, and car ownership) that likely contributed to their ability to work.

As has been found in prior research, multiple health problems were correlated with employment status and welfare receipt in the Urban Change sample. And yet it is striking that, despite this link, some women with multiple health problems *were* working. An important question is: *What enabled some women with multiple health barriers to work, while others did not work?* Put another way: Why is it that women in the work-only group and the welfare-and-work group were able to work, even if they had multiple health problems?

The Urban Change survey provides information about a number of characteristics and circumstances of sample members that could be considered employment enablers or facilitators, including: young age,[8] having some college education, responsibility for no more than one child, availability of a husband or partner to share household and parenting responsibilities, regular contact with the father of their preschool-age child,[9] ownership of or direct access to a car, lack of difficulty finding a trustworthy child care arrangement, positive work attitudes, and good social skills. Table 8.3 presents the percentage of women in the four work/welfare groups who had these enabling factors *among women who had two or more health barriers.* In each case, the group differences were statistically significant, suggesting that these factors could account for differences in the employment behavior of women facing multiple health barriers. Some of the enablers distinguished all employed versus nonemployed women. For example, women who worked — regardless of their welfare status — were younger, less likely to say they had difficulty finding a trustworthy child care arrangement, and less likely to say they preferred not to work so they could care for their families full time. However, for all the factors considered to be enablers, the group of former recipients who were working most consistently stood apart from the others. These women were more likely than others to have some college education, to have only one child in their care, to be living with a partner or husband, to have a preschool-age child who had regular contact with his the father, to have access to a vehicle, and to have excellent social skills as rated by the interviewers. Thus, health barriers appear to constrain a woman's ability to leave welfare and start working, but among those with multiple barriers, other factors either offset the health problems or provided ways of coping with the demands of a job.

---

[8] Young age was considered an enabler for several reasons, including higher energy levels, possibly greater familiarity with technological innovations that characterize most workplaces, and possibly less entrenchment on welfare. (Unfortunately, information about respondents' welfare history was not obtained in the survey, but this information will eventually be available through administrative records.)

III. Health Barriers and the Work and Welfare Experience

Health Barriers and the Work and Welfare Experience: Highlights of the Findings

- Among the Urban Change survey sample, working women with health barriers were more likely than those without such barriers to be working part time; they were also less likely to be working in jobs with fringe benefits, including health insurance.
- Welfare leavers with health barriers were more likely than those without barriers to have left welfare recently; they were also more likely to say that they had been terminated by the welfare agency rather than having left of their own accord.
- Among current recipients, the greater the number of health barriers, the greater the likelihood that the woman had been sanctioned in the prior year.

A. The Employment Experience in Relation to Health Barriers

While previous studies have demonstrated a link between health and nonhealth barriers to employment, on the one hand, and employment status, on the other, there is little systematic information about the extent to which health barriers are related to employment characteristics among former or current welfare recipients. Olson and Pavetti (1996) looked at barriers in rela-

---

[9] Regular contact with the child's father could enable mothers to work if the father is available for child care or even occasional babysitting (for example, when the child is sick).

The Project on Devolution and Urban Change

Table 8.3

Employment Enablers Among Women with Multiple Health Problems, by Work and Welfare Status[a]

Outcome (%)	Full Sample		Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Is under age 30	31.0	***	40.2	35.1	28.5	19.0
Has some college education	16.6	***	27.2	15.4	13.3	13.3
Has no child or only 1 at home	23.5	***	33.1	16.8	21.2	25.4
Lives with a husband or partner	17.5	***	29.3	13.1	11.8	27.5
Has a preschool-age child who sees father at least weekly	35.6	***	50.4	27.4	32.8	35.6
Respondent or immediate family member owns a vehicle	33.4	***	60.2	31.3	21.8	39.4
Does not have difficulty finding a trust-worthy child care arrangement	45.7	***	57.4	52.2	39.0	44.5
Does not prefer to take care of family full time rather than work	61.3	***	69.1	67.8	57.4	55.1
Rated highly by interviewer for social skills (9 or 10 rating)	57.1	***	68.4	53.4	54.8	52.1
Sample size	1,268		267	209	650	142

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

When linear analysis of covariance procedures was used to control for background characteristics, all the group differences in this table remained significant. The characteristics included site, age, educational attainment, race/ethnicity, citizenship status, marital/partner status, presence of a child under age 6, number of children in the household, and time elapsed between May 1995 and the interview date.

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

tion to continuity of employment, and they found that barriers were even more of an impediment to continuous employment (at least 50 weeks of the prior year) than to having ever worked in the prior year. For example, only 11.0 percent of those with at least one serious barrier (not counting low basic skills) had full-year employment, compared with 26.8 percent of those without such a barrier. Cancian et al. (2000) also reported that high-barrier women were substantially less likely than low-barrier women to have worked in all four quarters after a welfare exit. However, in addition to information about employment continuity, it would be useful to know the extent to which health problems are related to other aspects of poor women's employment experiences, such as hours worked, wages, benefits, and so on.

Table 8.4 presents selected employment-related characteristics of women in the two working groups, according to the number of health barriers. The pattern that emerged is not especially powerful, but it is consistent: The smaller the number of health barriers, the more likely the women were to have favorable employment situations. Unlike the Olson and Pavetti study, there was no statistically significant relationship between having health barriers and having held a job for at least one year. However, women with no health barriers were significantly more likely to be working full time, to have a fixed schedule, to be earning above the minimum wage, and to have jobs with fringe benefits.

Of particular note was the fact that women with health barriers were significantly less likely to have employer-provided health insurance for themselves and their children than were women with no health barriers. While it might be hypothesized that this difference in health insurance coverage resulted from the fact that women with many health barriers were less likely to be working full time, this was not the case. Among part-time workers, the number of health barriers was unrelated to receipt of employer-provided health insurance (not shown). However, among women working full time (30 hours or more per week), women with health barriers were substantially less likely to have medical benefits for themselves and their children than were women with no health barriers. For example, as Table 8.4 shows, nearly half (47.6 percent) the full-time workers without health barriers had employer-provided health insurance, compared with 32.1 percent of those with three health barriers or more.

Differences in earnings in the prior month in relation to number of health barriers were especially striking. Women without health barriers had average earnings of $1,013 in the month before the interview, roughly 50 percent more than the earnings of women with three barriers or more ($688).

Thus, health barriers were associated not only with lower rates of employment among women who had been or still were on welfare but also with less favorable employment outcomes among women who were working.

B. The Welfare Experience in Relation to Health Barriers

Another question about which there is little information is whether health barriers are related to the women's experiences with the welfare agency. In the Olson and Pavetti (1996) study using NLSY data, individual health and mental health problems were found to be consistently related to length of time on welfare. For example, 11 percent of the women who had been on welfare for five years or more said that they were not seeking work because of their own medical

The Project on Devolution and Urban Change

Table 8.4

Employment-Related Characteristics of Employed Women, by Number of Health Barriers[a]

Characteristic	All Working Women	No Health Barriers	1-2 Health Barriers	3+ Health Barriers
Worked 12 months or more in current job (%)	53.4	56.0	52.8	47.5
Works 30 hours or more per week (%)	72.5	76.5	71.0	66.5
Maintains a fixed schedule at current job (%)	68.8	72.9	66.7	65.8
Hourly wage				
Average, before taxes ($)	7.62 ***	8.07	7.55	6.97
Less than $5.15 (%)	13.3 **	8.9	13.2	18.1
$5.16 - $7.50 (%)	46.0	44.6	48.5	46.4
More than $7.50 (%)	40.6 **	46.5	38.3	35.5
Average earnings, prior month ($)	921.28	1,012.94	904.17	687.69
Has sick/personal days with pay (%)	43.6	46.5	41.9	42.2
Has medical benefits (%)	44.9	49.5	41.9	43.7
Has medical benefits for her children (%)	35.5	40.4	32.4	34.1
Has no fringe benefits (%)	44.5	38.8	46.8	51.9
Works 30 hours or more and has medical benefits (%)	38.6	47.6	34.8	32.1
Works 30 hours or more and has medical benefits for children (%)	30.7	38.5	27.7	24.3
Sample size	1,555	553	844	158

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

problems, compared with 4 percent of those on welfare for two years or less. And some 21 percent of the long-term recipients reported having a child with a chronic medical condition, compared with 14 percent of recipients with two years or less of welfare receipt.

Although the Urban Change survey did not ask detailed questions about the women's welfare history, some information about date of departure is available. Among the former recipients in the sample (that is, women in the work-only group and the no-work, no-welfare group), women without health problems were slightly more likely to have left welfare more than one year prior to the interview (see Table 8.5), but this difference was only marginally significant (p = .07). However, the reported reason for departure was strongly related to the number of health problems. Women with three health barriers or more were about 50 percent more likely than leavers without health barriers to say they were cut off by the welfare agency rather than departing of their own accord (56.6 percent versus 38.9 percent, respectively).

Nearly one-third (29.1 percent) of the welfare leavers with multiple health problems, compared with 10.2 percent of those without health problems, said that they had reapplied for welfare in the previous 12 months but had been turned down. Women with multiple barriers were also significantly more likely to report that they had had a dispute with the welfare agency in the prior year and that they had sought legal advice about a welfare issue. Although there was a tendency for women with more barriers to report that they continued to receive medical benefits after their welfare exit, this relationship was not statistically significant. However, the greater the number of barriers, the more likely the women were to say that they thought time limits were unfair.

Table 8.6 presents information about welfare experiences in relation to health barriers among current recipients (that is, women in the work-and-welfare group and the welfare-only group). According to these women's reports, those with health barriers were significantly more likely to have been sanctioned in the prior year than women with no health barriers.[10] One-third of the women with three barriers or more, compared with about one-fourth of those with none, said the welfare agency had sanctioned them. The individual health barrier most strongly associated with reports of sanctioning was physical abuse: 41.1 percent of women who had been physically abused in the prior year reported a sanction, compared with 28.6 percent of nonabused women. Other individual health barriers that were significantly related to sanctions included being at risk of depression (31.9 percent versus 27.0 percent) and having a child with a condition that constrained the women's ability to work (36.2 percent versus 27.9 percent) (not shown in tables). Consistent with the findings on sanctioning, the greater the number of health barriers a woman had, the greater the likelihood that she would report having had a dispute with the welfare agency in the prior year. Some 28.0 percent of the women with three health barriers or more, compared with 18.3 percent of those without any, said they had had such a dispute.

The survey also asked current recipients about their interactions with welfare staff. Interestingly, recipients with three health barriers or more were *less* likely than others to say that they had gotten personalized attention from their case managers. However, they were just as likely to

---

[10] Other studies have also found that sanctions are higher among recipients with barriers to employment. For example, a review of sanctioned cases in Minnesota revealed that in 76 percent of sanctioned cases the recipient had at least one barrier to employment (cited in Kaplan, 1999). However, it does not appear that sanctions have been studied in relation to health problems of recipients.

The Project on Devolution and Urban Change

Table 8.5

Welfare-Related Experiences of Welfare Leavers, by Number of Health Barriers[a]

Characteristics (%)	All Welfare Leavers	No Health Barriers	1-2 Health Barriers	3+ Health Barriers
Left welfare more than 12 months ago	72.6	75.7	71.8	66.4
Left welfare because agency cut her off	47.1 ***	38.9	50.8	56.6
Applied for welfare in past 12 months but was denied	16.3 ***	10.2	17.7	29.1
Had a dispute with welfare agency, past 12 months	20.1 ***	14.2	21.3	33.6
Sought legal advice about a welfare issue, past 12 months	2.0 *	1.2	1.9	4.6
Continued to get health insurance after leaving welfare	45.7	40.7	48.2	50.0
Thinks the time limits are fair	56.9 ***	67.5	52.1	46.4
Sample size	1,558	554	846	158

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

The Project on Devolution and Urban Change

Table 8.6

Welfare-Related Experiences of Current Welfare Recipients, by Number of Health Barriers[a]

Characteristic (%)	All Current Recipients	No Health Barriers	1-2 Health Barriers	3+ Health Barriers
Reports no exemption from participation requirements	60.3 ***	71.9	61.4	47.4
Has a health-related exemption from participation requirements	13.4 ***	3.7	9.4	31.8
Has an exemption for pregnancy or age of youngest child	9.2	6.5	10.4	8.7
Was sanctioned, past 12 months	29.8 *	24.8	30.1	33.6
Had a dispute with welfare agency, past 12 months	24.3 **	18.3	24.9	28.0
Case manager has given personalized attention	32.0 **	34.8	33.5	25.9
Welfare staff pushes her to get job quickly	51.4	54.5	51.3	49.1
Thinks welfare program has improved chances of employment	24.1 ***	26.5	26.6	15.8
Knows about the transitional medicaid benefits for exits due to employment	52.4 ***	59.3	53.2	44.6
Knows about the time limits	76.3	79.2	75.3	76.0
Thinks the time limits are fair	47.1 ***	54.6	47.4	39.4
Sample size	1,726	355	969	402

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

report that the welfare staff had pushed them to get a job quickly. Women with multiple health barriers were also less likely than other recipients to believe that the welfare program had helped their chances of getting or keeping a job.

Women in all three health barrier categories were equally likely to know about the time limits, but, like welfare leavers, women with barriers were less likely to think the time limits were fair. Interestingly, knowledge about the availability of transitional Medicaid following work-related welfare exists was higher among women *without* health barriers than among those who presumably would need such benefits the most because of health problems.

In summary, the welfare experiences of both welfare leavers and current recipients were related in many ways to the number of health barriers they faced. In general, the greater the number of health barriers, the less favorable the experience — that is, the less supportive they perceived the agency to be and the greater the likelihood that they would have had conflicts, in the form of sanctions, disputes, and terminations. While it is not possible to conclude whether the health barriers or other factors "caused" these experiences, these findings nevertheless have implications for welfare programs and policies, as discussed in Chapter 9.

Chapter 9

Reflections and Implications

I. Introduction

This concluding chapter presents a summary of the major findings from this report and also discusses possible interpretations and implications of those findings. First, however, several caveats should be noted.

The Urban Change survey and ethnographic samples were, by design, composed of women who had lived in the most severely disadvantaged neighborhoods in Cleveland, Los Angeles, Miami, and Philadelphia. In May 1995, administrative records indicated that all the women in the survey sample were unmarried welfare recipients caring for at least one child and living in neighborhoods with high rates of poverty and welfare receipt.[1] Thus, it is important to remember that the findings in this report are not based on a representative sample of welfare recipients but, rather, on a representative sample of current and former recipients from very poor urban neighborhoods — women who were potentially at especially high risk of experiencing the effects (good or bad) of welfare reform.

It is also important to keep in mind that the findings do not necessarily reflect any consequences of welfare reform — or, at least, consequences of reaching the time limits — because these women still had time remaining on their time-limit clocks when they were interviewed in 1998-1999. It is, of course, possible — and even likely — that the women's work/welfare status in the four research groups *was* affected by new welfare policies. That is, some of the working women in the sample were likely encouraged or urged to work by the welfare agency, just as some women in the no-work, no-welfare group may have left welfare to avoid the new participation requirements or as a result of a sanction for noncompliance with those requirements.

Finally, it should be remembered that the findings on health problems are based on self-reports of statuses and thus do not represent clinical diagnoses. The data are also limited by the absence of information about the severity of health problems.[2] Thus, evidence of a health problem does not necessarily indicate a permanent or severe disability that would make it impossible for a particular woman to obtain employment, to qualify for an exemption from the time limits, or to be eligible for Supplemental Security Income (SSI). However, if a transition to employment is to be successful, the presence of one or more health problems may require special services and an individualized response from the welfare agency.

---

[1] By the time of the interview in 1998-1999, some women had moved to better neighborhoods, but the majority had not.

[2] One further limitation is that the survey does not provide extensive information about the health of other family members — especially about other adults in the household. Some women likely had responsibility for ill or disabled family members, which could have further limited their ability to work.

II. Summary of Key Findings

A. Health in the Urban Change Population

The survey and ethnographic data clearly indicate that the women in the research samples were, as a whole, an especially disadvantaged group. Many had what could be considered important impediments to employment, including human capital barriers (for example, not having a high school diploma or GED certificate, or having no prior work experience), other structural barriers (such as having several children or a very young child in their care), and a variety of health problems that could interfere with their ability to take or keep a job.

This report repeatedly documented that the Urban Change women had substantially higher rates of personal health and mental health problems and children's health problems than is true in national samples. As summarized in Table 9.1, the women in the Urban Change survey sample were more likely than national samples of adults to be food insecure, to have housing problems, to be in fair or poor health, to have unfavorable scores on a widely used measure of emotional well-being, to be overweight, to smoke, to be uninsured, to have had numerous doctor visits in the prior year, and to have children in fair or poor health.

For several health indicators, there were no appropriate national comparisons available, but the absolute values further suggest burdens that are not typical of women in their twenties to early forties. For example, many of the women in the Urban Change survey sample:

- had a potentially hazardous housing problem, such as vermin or a wiring, heating, or plumbing problem (54 percent);
- lived in crowded households (21 percent);
- had been robbed or mugged in the prior year (17 percent);
- had a health limitation that constrained moderate activities, such as pushing a vacuum cleaner (37 percent);
- felt highly stressed in the prior month (50 percent);
- had unmet medical and dental care needs, either personally or among other family members (30 percent);
- had a child age 2-6 who had never seen a dentist (13 percent); and
- had an adolescent child who needed glasses but did not wear them (11 percent).

These women's health problems were often compounded in several respects. First, as documented in Chapter 8, many of them had more than one health problem, exacerbating the difficulties they would face (or had already faced) in securing a suitable job, leaving welfare for work, and remaining employed. Moreover, many lived in conditions of chronic stress caused by material hardships and difficult interpersonal relationships that left them perpetually vulnerable to assaults on their health. Second, the health problems of these women were often experienced

240

The Project on Devolution and Urban Change

Table 9.1

Comparison of Outcomes on Selected Indicators for Urban Change Respondent Survey Sample and National Samples

Outcome	Urban Change Sample	National Sample	National Comparison Group
Average percentage of income spent on food[a]	29	8	All households
		12	Households in which reference person is without HS diploma
Food insecure[b] (%)	49	10	All families
		36	All families below poverty
Childhood hunger (%)	5	1	All families with children
Worst-case housing needs (%)[c]	34	7	All families
Reports fair to poor health (%)	25	8	Women age 25-44
		12	Black women age 25-44
Score of less than 40, physical component of (SF-12)[d] (%)	31	10	Adults age 18-44
Score of less than 40, mental component of (SF-12)[d] (%)	26	16	Adults age 18-44
Currently smokes cigarettes (%)	40	23	Women over 18
Overweight (BMI greater than 25)[e] (%)	66	37	Women age 20-34
		50	Women age 35-44
Uninsured (%)	10	16	Nonelderly adults
Average number of doctor visits, past 12 months	6.0	5.4	Women age 18-44
Preschool-age child in fair to poor health (%)	8	3	Children under age 6
Adolescent child in fair to poor health (%)	12	3	Children age 5-17

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] Total income of the immediate family includes food stamp benefits but does not include Earned Income Tax Credits (EITCs).

[b] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

Table 9.1 (continued)

[c] Families have worst-case housing needs if they have no rental assistance and pay more than 50 percent of their income (not including food stamps) for rent and utilities.

[d] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[e] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

in addition to other constraints that presumably pose further challenges to finding and keeping a job — constraints such as those included in the nonhealth multiple barrier index described in Chapter 8 — and they also faced a host of other impediments that were revealed in the ethnographic interviews, such as turbulent living arrangements, transportation limitations, lack of a telephone, experiences of discrimination, and so on. Third, the women's impediments to employment need to be understood within a context of the care they needed to provide to their children — children who were at higher-than-average risk of health, academic, and behavior problems with which the mothers needed to contend, typically without the assistance of the children's fathers. The issue of the reciprocal effects of children on mothers and of mothers on children is discussed later in this chapter.

B. Health in the Four Work/Welfare Groups

The findings indicating that the Urban Change respondents and their children were less healthy than national samples is not surprising, given that almost all were poor. As previously noted, there is ample documentation that people with low incomes in general, and welfare recipients in particular, have higher rates of health problems than those with higher incomes, and so the present findings simply add to the vast literature on the link between health and financial resources.

However, the findings in this report are important because they offer *current* information about the scope and intensity of the health problems of welfare recipients and former recipients, at this critical policy juncture. Moreover, to date there has been relatively little information about factors relating to health variation *within* a low-income or welfare population. As shown in Appendix E, which summarizes the results of multiple regression analyses, several characteristics of the survey respondents did account for differences in their health outcomes. For example, age, citizenship status, education credentials, and total family income were related to a number of key health outcomes in predictable ways: Women who were older, noncitizens, less well educated, and poorer were more disadvantaged in terms of health than others.[3] None of these characteristics, however, was as consistently related to the women's health circumstances as was their work/welfare status.

The findings in the present study suggest that it may be misleading simply to compare welfare leavers and welfare recipients in terms of their health and other characteristics, as several recent studies have done. For example, Loprest and Zedlewski (1999) found that recipients and leavers did not differ significantly in terms of having poor mental or general health. However, in the present study, welfare leavers were quite heterogeneous and included women with among the best and the worst health statuses. In fact, *all four work/welfare groups in this study had persistently different health profiles.*

The Urban Change findings indicate with great regularity that the women who had left welfare and were employed were living in healthier circumstances — that is, they had fewer health-relevant material hardships — than the other women. And women in the work-only group were, in fact, more healthy, possibly explaining their ability to enter the labor force. For example, compared with women in the other three groups, former recipients who worked were significantly *less* likely (even after controlling background characteristics) to:

---

[3] Race and ethnicity were not important predictors of health outcomes in this low-income sample once other factors were simultaneously controlled. Marital status/cohabitation was related to material hardships but not to other health outcomes. See Appendix E for further information.

- have an unfavorable score (under 40) on the physical component of the SF-12 (22 percent versus 36 percent);
- be in fair or poor health (17 percent versus 30 percent);
- have a health condition that constrained work (12 percent versus 30 percent);
- be at risk of depression (40 percent versus 54 percent);
- have numerous doctor visits in the prior year (average of 4 visits versus 7);
- have a child with an illness or disability that constrained work (13 percent versus 23 percent); and
- have a preschool-age child in fair or poor health (5 percent versus 9 percent).

Not only were women in the work-only group less likely to have individual health problems, but they were also less likely to have multiple health problems, as measured by the multiple health barrier index described in Chapter 8. Only 26.2 percent of the employed former recipients, compared with 49.1 percent of the women in the other three groups, had multiple health barriers.

However, although women in the work-only group were the healthiest,[4] they were not similarly advantaged in terms of health insurance and health care access. In terms of health care, the two groups of women who continued to receive welfare benefits were substantially better off than the welfare leavers — whether the leavers worked or not. Compared with welfare recipients, former recipients (that is, the women in the work-only group and the no-work, no-welfare group) were significantly more likely to:

- be without health insurance at some point in the prior 12-month period (48 percent versus 16 percent);
- be uninsured in the month before the interview (36 percent versus 6 percent);
- have one or more uninsured child (29 percent versus 7 percent);
- lack a usual source of medical care (16 percent versus 8 percent);
- report that access to health care had gotten more difficult in the prior year (38 percent versus 28 percent);
- have unmet medical care needs (34 percent versus 15 percent) either personally or among other family members; and

---

[4] Women in the work-only group were healthiest and, as discussed in Chapter 8, also had the fewest structural and human capital barriers, such as low educational attainment. Additionally, former recipients who worked were most likely to be receiving child support and to have children who saw their fathers regularly, indicating higher access to an important financial and emotional resource.

- have unmet dental care needs (37 percent versus 16 percent).

Among the women who had exited welfare and were working, their health and their children's health (relative to other Urban Change families) can be seen as reasonably good on average; therefore, the absence of health insurance might not pose severe problems for some.[5] However, the same cannot be said of the welfare leavers who were *not* working: Their health problems were nearly as numerous as the women in the welfare-only group *and* they had the highest rate of being uninsured of the four groups, which makes them the group with the most compromised health situations. Nevertheless, in both welfare leaver groups there were substantial health risks. Among the women in the no-work, no-welfare group who lacked health insurance at some point in the prior year, a full 40.6 percent had two or more health problems. And among the uninsured women in the work-only group, one-quarter (25.1 percent) had multiple health problems.

This underscores an important point, namely, that *even the most advantaged group in this sample had a high rate of health problems.* Even though the women in the work-only group had the fewest health problems, their situations were troubling. Substantial percentages of them were food insecure (41.8 percent), had worst-case housing needs (17.9 percent), and had one or more potentially hazardous housing problem (46.4 percent). Although women in the work-only group were healthier than women in the other three groups, they were not as healthy as national samples of same-age women. For example, 17 percent described their health as fair or poor, compared with 8 percent of women age 25-44 nationally — and compared with 12 percent of African-American women in that age group nationally (National Center for Health Statistics, 1999). Thus, it appears that health risks remain high even among welfare recipients who are able to move into paid employment — and that the risks can be exacerbated by the fact that many lose health insurance.

III. The Link Between Health and Employment

As discussed in Chapters 1 and 4, there is considerable documentation of the relationship between health and employment: People who are healthy are more likely to be working than those who are less healthy. There are three possible explanations for the work/welfare group differences in health outcomes among the Urban Change sample:

1. *Health affected employment and welfare status.* Women who were healthier were better equipped to leave welfare and enter the labor force.

2. *Employment status affected health status.* Women who got a job became healthier as a result of their employment.

3. *Other characteristics affected both health and employment.* Both women's health status *and* their ability to work were caused by other factors — that is, the relationship between health and employment is spurious.

In the heuristic model in Figure 1.1 (which was based on the research literature), health is viewed as a direct and immediate determinant of women's employment and welfare behaviors and, through this link, as an indirect contributor to family income; this corresponds to the first explanation. The model further suggests that, through more distal pathways, employment can also affect health and mental health outcomes (for example, by reducing material hardships and health care access through higher income levels). The cross-sectional Urban Change data cannot reveal with certainty which of these explanations is correct. However, the evidence strongly suggests that the first explanation is most salient, although reciprocal effects are also likely.

---

[5] Of course, health crises can occur at any point, even in the absence of chronic health problems or a history of susceptibility to illness.

First, let us consider the third explanation, which invokes external factors as contributing to both poor health and women's ability to work. Characteristics that are known from other studies to be correlated with both employment and health status include age, educational attainment, number and ages of children, city, and race/ethnicity. In the Urban Change sample, these factors — with the exception of race/ethnicity — *did* correlate with certain health outcomes and also with work/welfare status. However, the work/welfare group differences in health outcomes persisted even when these and other background factors were controlled. In fact, work/welfare status was substantially more consistent than any other characteristic in explaining individual differences in health outcomes. It is possible, of course, that other, unmeasured factors are the "real" cause of both employment and health status.[6] It seems unlikely, however, that such characteristics — if they are powerful determinants of health and employment — would have failed to be identified in previous research or in theoretical discussions. Thus, this third explanation does not appear to have strong support.

The second explanation is that working had a positive effect on the women's health outcomes. There is some research evidence indicating that employment has beneficial effects on people's health. For example, at least two longitudinal studies have found that employment is associated with slower declines in health (Ross and Mirowski, 1995; Yelin and Trupin, 1999).[7] The positive effect of employment on health has been hypothesized in the literature as reflecting several mediating factors:

1. Working improves self-esteem and, consequently, one's *mental health;* this, in turn, results in benefits to physical health.

2. Working improves a person's *financial situation;* this, in turn, leads to improved material resources, living arrangements, and health care, which all contribute to better health.

3. Working improves access to *social support*, and social support has a positive influence on health.

---

[6] In addition to background characteristics previously described (see Appendix E), other variables were included in regression models to see if work/welfare group differences in health would be eliminated: receipt of welfare as a child, having had an out-of-wedlock birth, lack of any work experience, having been born outside the United States, and having a language barrier. Work/welfare group differences remained strongly significant even with these additional factors controlled.

[7] However, there is also some evidence (for example, Karasek and Theorell, 1990) suggesting that the health benefits of employment may be restricted to jobs that offer opportunities for flexibility, creativity, and decision-making — that is, the types of jobs that women in the Urban Change sample would be unlikely to hold.

If the observed work/welfare group differences in the Urban Change survey sample primarily reflect the contribution of employment to good health, it might be expected that group differences in health status would disappear when these mechanisms were controlled. However, this did not occur — at least, with measures of the mediators available in the survey. In the regression model predicting poor physical health — as measured by scores less than 40 on the physical component of the SF-12 — the following variables that correspond to the three hypothesized mediating factors were included, in addition to the other background characteristics previously described:

1. *Mental health:* being at risk of depression, having a high level of stress in the prior month, feeling as good as other people;
2. *Financial situation:* total family income in the prior month, total number of material hardships; and
3. *Social support:* having felt lonely in the previous week.[8]

All these variables (except loneliness) *were* found to be significantly related to women's physical health, as measured by unfavorable scores on the SF-12. However, these variables did not eliminate the significant work/welfare group differences. Even with these hypothesized mediating variables statistically controlled, women in the work-only group were least likely to have physical health problems. *These analyses suggest that the relationship between employment and health outcomes did not occur primarily because of the beneficial effects of employment on health.*

There are additional types of evidence that diminish the credibility or salience of the second explanation as the primary causal mechanism. First, for some health outcomes, the explanation that employment affects health makes less intuitive sense. It certainly seems plausible that employment could "cause" or influence better health among these women, for example, by improving their financial situations or their self-esteem. However, it seems less likely that employment could have *prevented* a child from having a health problem or disability than that such a problem interfered with a mother's employment. For example, thinking about the serious illnesses among children in the ethnographic sample, it does not seem plausible that these children could have avoided cancer, HIV infection, cardiac problems, and seizure disorders had the mothers been employed — yet these conditions had clear implications for the mothers' ability to take a job.

Additionally, as described in Chapter 8, health problems were related to employment situations even among those employed. For example, women with multiple health problems were less likely than other employed women to be working full time, which could mean that the health problems constrained their ability to manage a full-time work schedule.

Of the three explanations concerning the link between women's health and employment, then, the one that seems most plausible as the primary causal mechanism in the Urban Change population is that women's health and the health of their children affected the women's ability to work. This interpretation is consistent with findings from longitudinal studies. For example, Yelin and Trupin (1999) found that employed people who reported in 1998 that they had a health problem were more than twice as likely as those without a health problem not to be working in 1999. It has also been found that health problems induce greater use of welfare — even when the effect of poor health on hours of work is controlled (Blank, 1987).

---

[8] Perceived loneliness is not an ideal measure of social support, but, unfortunately, the survey did not include any formal social support measure. However, one other variable widely considered as a social support indicator — living with a husband or partner — *was* included in the regressions and similarly failed to eliminate work/welfare group differences in health status.

The first explanation also has considerable validity on its face. Illnesses and chronic health conditions clearly impair energy level, concentration, and physical capacity, all of which can undermine productivity and work effort. Moreover, some medications lead to drowsiness, dizziness, or other side effects that can make employment difficult or even hazardous. Health problems could force women to quit their jobs (or not look for jobs in the first place) if they feel physically unable to perform job duties. Indeed, when nonworking women in the Urban Change survey sample were asked directly why they were not employed, the majority (56.0 percent) of women with three health barriers or more explicitly mentioned a health-related reason, compared with 8.0 percent of the women with none of the eight barriers on the multiple health barrier scale.[9] Additionally, health problems could lead to dismissals as a result of frequent absences or inability to work efficiently or skillfully. The health problems of children are also formidable barriers to employment, as so clearly described in the ethnographic data. Mothers of sick children may have to be absent fairly often to care for them during bouts of illness and to take them to medical appointments. Especially in the types of low-wage jobs that these women typically get, flexibility in work schedule is not the norm; nor do most of these jobs offer such benefits as sick pay or vacation days that can be used to address health care problems. Without sick pay, working mothers risk either losing their jobs or having a reduced paycheck when they or their children are ill.

As previously noted, the women in the Urban Change sample who were not working often had multiple health and nonhealth problems: 96.4 percent of the nonworking women had at least one of the 13 health or nonhealth barriers, and *83.9 percent had at least two barriers*. A single barrier might have minimal effect on women's employment, but as the impediments mount up, the obstacles become increasingly difficult to overcome — both because the women themselves have to cope with the barriers and also because the barriers make them less attractive to prospective employers. Not having a diploma, for example, might not in itself disqualify a woman from certain jobs, especially in a strong economy. However, an employer might be reluctant to hire a depressed high school dropout with no prior work experience who has a sick child at home[10] — and she herself would have to struggle in the job if it were offered to her because of her own and her child's needs, especially if the job did not offer health insurance.

In addition, many of the nonworking women lived in circumstances that could undermine employment. For example, women who are food insecure and rely on food stamps and food pantries may fear that taking a job would make it difficult to maintain these benefits, because their work hours could conflict with access to these resources. Women who live in dangerous neighborhoods may worry about their safety getting to and from their jobs, and about the safety of their children in transit to child care. And — perhaps the biggest concern for those with health problems — women are apprehensive about what will happen to their health insurance when they leave welfare. The ethnographic data highlight the strong feelings that welfare mothers have about health care coverage for themselves and their children.

---

[9] Among nonemployed women with no health barriers, the most frequently cited reason for not working was their inability to find a job (30.7 percent), followed by their current participation in an educational or training program (16.5 percent).

[10] Indeed, there is evidence from a 1997 survey of employers in three Michigan cities (Holzer, 1999) that many employers were willing to fill jobs with unskilled welfare recipients but that the employers were less concerned with traditional credentials such as education and work experience than with "soft skills" such as punctuality and dependable attendance — criteria that pose challenges to women with health problems or whose children are ill.

In conclusion, for some women in this population, the evidence suggests that health problems are a likely deterrent to employment (and thus to leaving welfare) and also exacerbate other constraints that make it difficult to obtain the types of jobs that offer the health care coverage they need. This hypothesis can be explicitly tested later in the Urban Change project, when administrative data for these women become available from welfare and Unemployment Insurance earnings records for the years 1992-2000.

IV. Mothers and Their Children

The Urban Change sample comprises disadvantaged mothers, almost all of whom were single at the time of the interview. Thus, it is important to remember that, in addition to the health problems many of these women had, and in addition to other human capital deficits that are known to limit their employability, these women were responsible for the care and safety of their children, often without financial or emotional support from the children's fathers. The women who were working had developed strategies for the care and supervision of their children while they were at work. Women who were still on welfare without working would need to develop such child care plans in order to work — which, because of the welfare time limits, most of them presumably must do fairly soon.

The women's parenting responsibilities tended to be more complicated than those of middle-class mothers who work. First, few of these women had a partner or husband who could help to shoulder caretaking and supervisory responsibilities. And, as indicated in the ethnographic data, women living with a man could not always count on his assistance, and some had additional worries stemming from difficult or even unsafe or suspicious relationships between the man and their children. Second, many of these women lived in crime-ridden inner-city neighborhoods where anxieties about their children's safety and conduct were understandably high. Third, these mothers had children with higher-than-average health problems,[11] which impacted on their mothers in numerous ways, as the ethnographic data illustrate. Caring for a sick child is time-consuming and worrisome — and it is made even more worrisome when there is a loss of health insurance or a risk of losing it.[12] As the women in the welfare groups reach the time limits and become employed, they will be dealing with their children's health and other problems even as they have less time available for parenting.

---

[11] Many children in this sample also had a number of academic and behavior problems — problems that are stressful to mothers and that require ongoing monitoring and intervention (not shown).

[12] Moreover, research has shown that individuals subjected to the stress of caring for chronically ill family members are themselves at risk of adverse effects on their own immune systems (Kiecolt-Glaser and Glaser, 1995).

The Urban Change data indicate that while children's health and other problems have implications for women's ability to transition to employment, women's health problems also have implications for their children's well-being. The children of these women were at higher-than-average risk of living in homes with mothers who were depressed, had physical limitations, had had episodes of homelessness, had been victims of domestic violence, and had substance abuse problems. The children's vulnerabilities were not randomly spread across the sample; they tended to be more concentrated among mothers who were not working. It remains to be seen what will transpire in these children's lives as the women reach the end of their time limits.

V. Implications of the Findings

Information about the health of current and former welfare recipients has a number of implications for public policymakers and for agencies working with this population. This section discusses some of those implications.

A. Transitions Off Welfare

The current cross-sectional Urban Change data cannot predict which direction these women's lives will take. Nor do the data provide information about the ultimate effects of welfare reform on women's work/welfare trajectories or on their health. However, it is possible to make some speculations based on interpretations of these data — speculations that can be tested more rigorously when all the Urban Change data from the various study components are available.

Except for those who may qualify for exemptions or extensions, all the women in the two recipient groups will leave welfare fairly soon as a result of the time limits. That is, after they reach the time limits, nonexempted recipients will necessarily transition either to the work-only group or to the no-work, no-welfare group. Based on the data in this report, it seems likely that many — and perhaps most — of the women in the work-and-welfare group *will* be able to leave welfare for employment. Although the women who were combining work and welfare had more barriers to employment than those who had already left welfare for work, they had far fewer barriers than women in the two nonworking groups. Moreover, some of their barriers will be reduced over time (for example, their young children will get older) or may be eliminated (for example, some 15 percent were in school or training and may therefore improve their credentials). Nevertheless, as a group they are unlikely to have employment situations as favorable as the women who had already left welfare and were working at the time of the interview. This expectation is based on the fact that those who had previously exited had more human capital resources and fewer health barriers; it is also consistent with the results of a recent study that compared two cohorts of welfare leavers and found that the second cohort was doing worse (for example, had lower earnings, higher poverty rates), largely because of differences in the characteristics of the leavers (Cancian et al., 2000).

Undoubtedly, some of the women in the welfare-only group will also leave welfare for work. However, on the whole, *current recipients who were not working looked more like women in the no-work, no-welfare group than like those in the work-only group*. For example, the majority of working former recipients (72 percent) had no more than 2 of the 13 barriers on the combined health/nonhealth multiple barrier index. But only 34 percent of the women in the welfare-only group — and 40 percent of those in the group of nonworking former recipients — had two barriers or fewer on the combined health/nonhealth multiple risk scale. These two groups of women were similar in terms of education credentials, employment experience, and health problems, all of which contribute to women's ability to take and keep a job. Many of the women in the welfare-only group would fall into a category that is increasingly referred to as the "hard to employ." If their barriers are not addressed, then some of these women are likely to become members of the no-work, no-welfare group when they reach the time limits.

As previously noted, welfare leavers who were not working were especially disadvantaged. They had, as a group, multiple health problems and other barriers to employment, and they appeared similar to the nonworking welfare recipients — *except* that most did not have health insurance. It is important to recognize that welfare reform did not create this group; studies that have examined work and welfare dynamics regularly find former recipients who are not working. But when the time limits hit, this group is likely to grow and to be composed of more disadvantaged women — and fewer women who exit welfare as a result of a marriage.

B. Implications for Welfare Policies and Programs

The 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) created new opportunities and challenges for states. Many state welfare agencies are taking advantage of the unprecedented flexibility and financial resources they now have for developing innovative programs to reduce welfare dependence and move people into jobs. However, states must now, for the first time, engage virtually their full caseloads in work-related activities. Under the Job Opportunities and Basic Skills Training (JOBS) program — the federally mandated welfare-to-work program that preceded Temporary Assistance for Needy Families (TANF) — welfare recipients who were "ill or incapacitated" were categorically exempt from participation in work-related activities.[13] (Thus, many women in the nonworking recipient group in this study would likely have previously been granted an exemption.) Now, because of the two-year work requirement and mandatory work participation rates as set forth in PRWORA, states are working with recipients who have more health and other barriers to employment (the "hard to serve") than clients did in the past, and they must develop appropriate strategies that balance the needs and limitations of their clients with their own desire to avoid financial penalties by meeting federal participation standards. The findings from the present study have programmatic implications for state welfare agencies that are now operating programs quite different from earlier programs. The findings also have implications for welfare policy at both the state and the federal levels. In particular, some of the findings in the present study can play a role in informing upcoming deliberations regarding PRWORA reauthorization, which is scheduled to occur by September 2002.

1. Screening and Assessments. A universal work-first strategy that welfare agencies have adopted to encourage quick participation in the labor force may have been appropriate for the recipients with the fewest problems when PRWORA was enacted, as well as for most new applicants. Such a strategy likely moved as many recipients as possible into jobs relatively fast —

---

[13] Under JOBS, welfare recipients were considered ill or incapacitated when they faced conditions ranging from temporary illnesses to long-term health problems that were not severe enough to qualify the person for SSI benefits (Thompson, Holcomb, Loprest, and Brennan, 1998).

during a period when jobs were plentiful. Recipients who left welfare for work prior to reaching the time limits were plausibly among the best suited of the caseload for transitioning into employment, because they were the women with the fewest barriers (and, as discussed in Chapter 8, the greatest number of employment-enabling factors).[14]

However, the findings in this report suggest that programs that require all recipients to immediately seek employment could pose problems for women with certain health and emotional barriers and for women with multiple impediments to employment in the current time-limited environment. For three major reasons, it seems crucial for welfare administrators to be able to identify these women through appropriate screening and assessment procedures. First, assessment information is critical as a planning tool. States now make numerous policy, programmatic, and resource allocation decisions in which assessments could play a key role — decisions about sanctioning policies, exemption policies, diversion, service provision, and so on. Planning is handicapped unless it is based on accurate information about the prevalence of constraints facing recipients. Second, assessments are needed to plan a course of action for women with persistent and complex barriers who now face time limits to welfare receipt. Third, in the absence of some form of assessment, it is difficult for states to know the extent to which they are in compliance with the Americans with Disabilities Act (ADA) of 1990. PRWORA specifically requires states to be in compliance with ADA, and thus states need to ensure that their programs and policies do not discriminate against, or have the effect of discriminating against, people with disabilities. The ADA definition of disability ("a physical or mental impairment that substantially limits one or more of the major life activities") is sufficiently broad that many of the women in the welfare-only group of the Urban Change survey sample might well be considered disabled.

Accurate identification of clients with health barriers and disabilities is an important step in working with these clients. Such identification calls for both screening (to determine the possibility that a problem or disability exists) and assessment (for a fuller diagnosis of the nature and severity of the problem).

At the present time, states appear to vary considerably in their approach to screening and assessment. Some use formal instruments to identify particular problems such as substance abuse (for example, Florida uses the Substance Abuse Subtle Screening Inventory, or SASSI). Other states rely on clients' self-disclosures during interaction with staff or with subcontracted service providers, and on monitoring techniques built into case management, rather than on formal assessment tools as a means of identifying hard-to-place clients. Such strategies may be sufficient for identifying some clients with barriers, but they may miss others — and such an approach clearly cannot provide systematic information for planners. It does not appear that many states incorporate routine protocols for identifying a range of the major health barriers to employment noted in this study, such as major depression, drug and alcohol problems, domestic violence, and turbulent housing situations that place women at risk of homelessness. Brief screening instruments do exist, however. For example, there is a four-item measure of mental health, based on items in the CES-D scale, that could be used in mental health screening, and an instrument known as the Family Assessment Tool (FAT) could be used to identify a wide range of barriers (Johnson and Meckstroth, 1998).

---

[14] Indeed, as noted in Chapter 8, the fewer the health barriers a woman had, the greater the likelihood that she had left welfare more than a year before the survey interview.

In the absence of formal screening and assessment procedures, most states appear to have adopted an unstated strategy in which recipients with the most severe problems are "smoked out" simply by being the ones unable to comply with participation and other requirements. Indeed, some states have deliberately avoided expensive, universal up-front assessments for all recipients, perhaps regarding such assessments as an obstacle that could actually slow down the process of getting the majority of recipients into jobs. In other cases, such as in Cleveland, the welfare agency is stepping up assessment and intervention activities for women who will soon hit the time limit and are not working. While such efforts are likely to prove beneficial for some, the timeliness of this approach should be considered. Strategies to address the needs of women with a severe problem or multiple barriers to employment take time to succeed. The pressure of time-limited welfare has implications for the design, intensity, and duration of appropriate services, suggesting that early identification of problems could be crucial.

In light of the high rate of health and nonhealth barriers among recipients, states might want to consider allocating resources to the development of appropriate procedures for screening recipients and to the creation of a climate in which recipients and staff recognize the value of identifying and addressing employment constraints. Full-blown assessments may not be necessary or desirable for most recipients, but effective, low-cost screening mechanisms, followed by more elaborate assessments for those with potential health and mental health problems, could give welfare staff the time they need to arrange for needed ameliorative services. For example, Los Angeles County's welfare-to-work program has begun using a short, self-administered questionnaire during the intake process that asks about substance abuse, mental health problems, and domestic violence. Clients who indicate that they may have a problem are referred immediately to a social worker for a clinical assessment.

In the absence of universal screening, assessments of sanctioned (or about-to-be-sanctioned) clients may prove valuable, given the findings in this report that women with certain barriers such as domestic violence and depression were more likely than others to have been sanctioned. For example, in Cleveland the welfare agency has contracted with nonprofit social service agencies to make home visits to every family who is sanctioned for noncompliance with welfare-to-work requirements. The home visitors are trained to identify barriers and to arrange for services that could help the family regain compliance.

2. Staff Training. Before PRWORA, most welfare staff never had to work with clients who had health problems or disabilities, because such clients were previously given categorical exemptions from the JOBS program. Now that staff must work with virtually all clients on the caseload, they need to develop new skills so that they can identify potential barriers, understand the impact of these problems on employment, develop suitable plans to help move these clients from welfare to work, and make appropriate referrals. Welfare staff would likely benefit from training on issues relating to the problems described in this report.

3. Services. Service provision to promote a permanent transition from welfare dependence to self-sufficiency is an issue of relevance in terms of both program and policy design, and it is also of relevance to all four work/welfare groups considered in this report. Because of the time limits, it is important to develop strategies not only to move people into jobs but also to enhance the likelihood that they will stay in them.

Welfare agencies have options regarding the provision of services to address various barriers, whether to "count" certain services toward participation requirements, and whether to grant temporary deferrals — or more permanent exemptions — from requirements and time limits. Some of the barriers identified in this study (such as serious chronic health problems) may be too intractable to remedy to the point where the women could become totally self-sufficient — although it should not be assumed that these women are totally unable to work and would not benefit from employment-related services. Decisions need to be made regarding how such cases are to be handled at both the program and the policy levels.

Other barriers identified in this study, however, could potentially be diagnosed and addressed through interventions. In particular, substance abuse and mental health services may prove to be critical to certain segments of the welfare caseload — as well as to women who leave welfare for work and find it difficult to sustain employment. Women in all four work/welfare groups were at high risk of depression, and major depression is the leading cause of disability in the United States. Yet, despite the fact that depression is treatable, only 23 percent of adults with *diagnosed* depression receive treatment (U.S. Department of Health and Human Services, 2000b). Thus, it seems possible that aggressive mental health services could have favorable effects on the ability of such women to enter and remain in the labor force.

Enhanced case management is another service strategy that might benefit recipients with multiple or complex barriers. Programs with enhanced case management services could include such features as regular home visits, mentoring, or the use of multidisciplinary service teams involving coordination with other service providers. Indeed, coordination with other agencies and providers is undoubtedly a key ingredient in developing effective strategies for working with hard-to-place and hard-to-employ recipients. Even with extensive training, welfare staff will not have the skills needed to address the often deep-rooted health and mental health problems of some of these women.

It is noteworthy that special provisions have been made to address the special needs of victims of domestic violence. The Family Violence Option (FVO) is an amendment to PRWORA and is sometimes referred to as the Wellstone-Murray amendment. States adopting the FVO[15] can offer domestic violence victims counseling, safety planning, and other needed services before they seek work.[16] Federal regulations promulgated in April 1999 indicate that states implementing the FVO will not be subject to federal financial penalties for failing to meet required work participation rates if the rates are reduced by temporary exemptions granted to domestic violence victims. Policymakers might want to consider whether similar provisions should be made for mental health problems or other health problems described in this report.

---

[15] Among the four states in the Urban Change study, only Ohio elected not to adopt the FVO. Ohio's state plan does, however, allow domestic violence victims to be excused from regular assignments and to participate in alternative activities, but participation in such activities does not stop the state's 36-month clock for receipt of benefits (Raphael and Haennicke, 1999).

[16] Anecdotal evidence suggests, however, that welfare agencies provide such services to relatively few women and that part of the problem lies in identifying domestic violence victims. This only underscores the importance of appropriate screening and assessment.

Of course, it is likely unrealistic to expect that all or even most women with multiple barriers to employment can be served with a suitable intervention.[17] Given their health and personal impediments, women with multiple barriers may also face obstacles to accessing specialized services that could help them address their needs; for example, clients' health and mental health problems, neighborhood safety concerns, language problems, educational deficits and learning disabilities, and so on could pose obstacles to receiving or sustaining the very services they need.

Among clients with fewer problems, welfare agencies still need to consider services designed to enhance the likelihood that they can find and sustain full-time, regular employment in jobs with benefits. One strategy is to provide services to strengthen employment "enablers." As discussed in Chapter 8, even women with health-related problems often *do* work, and some are able to sustain continuous employment. In this study, women with health barriers who worked were more likely to have certain enabling characteristics than those who did not work, and some of these enablers (education credentials, English language skills, social skills) are amenable to intervention.

Another service that is critical to virtually all recipients and former recipients is child care. Of particular relevance to this report is the need for specialized child care — that is, care for children who are ill or who have special needs. The difficulties that women face when they have children who become ill or who have a chronic health problem have not received much direct attention, and yet they are a key impediment faced by working welfare recipients or leavers, as well as by mothers who are required to participate in work-related activities as a condition of keeping welfare benefits.

4. Sanctions. The federal TANF law requires states to sanction recipients who do not participate in mandated activities without good cause, and it enforces that requirement through financial penalties to the state's block grant. However, states have flexibility in terms of determining what constitutes noncompliance, in establishing the amount and duration of the sanction, in establishing an appeals process, and in determining the effects of a sanction on Medicaid and food stamp benefits.

The findings of this study have implications relating to sanctions. Barriers that make employment difficult can also be impediments to participation in mandated activities. Recipients with a complex set of barriers, who are neither exempt nor given specific help to resolve these problems, are especially vulnerable to losing assistance through sanctions for failure to meet participation requirements. Indeed, a substantial minority (30 percent) of those currently on welfare in the Urban Change survey sample reported that they had been sanctioned in the previous 12 months.[18] And, as discussed in Chapter 8, health barriers were significantly related to sanctions and to disputes with the welfare agency: 33.6 percent of the welfare recipients with three health barriers or more reported a sanction, compared with 24.8 percent of those without a health barrier; and 28.0 percent of those with three barriers or more said that they had had a dispute with the welfare agency, compared with 18.3 percent of those with no health barriers. Certain individual barriers — domestic violence, depression, and having a child with a health problem — were especially likely to be associated with sanctioning.

---

[17] There is ample evidence from rigorous evaluations that welfare-to-work programs have had some success in increasing employment among recipients with modest barriers, but less success with those who have multiple impediments (see, for example, Gueron and Pauly, 1991). However, it is important to note that these evaluations were undertaken at a time when welfare agencies had little or no experience working with hard-to-place clients and also had fewer resources with which to assist them.

Strategies are needed to avoid inappropriate sanctions for women whose noncompliance is associated with serious or multiple barriers. First, cogent communication is essential to an equitable and effective sanctioning policy. Recipients need to know the agency's expectations and the consequences if they do not comply. This means communicating information in an appropriate way for those with poor basic skills and for those who do not speak English,[19] and it means communicating frequently enough to ensure that messages have been assimilated. Equally important are procedures to make sure that clients are aware of the availability of "good cause" exemptions and of conciliation processes through which staff and clients can work together to address the underlying causes for noncompliance. Finally, states have latitude in defining good cause exclusions and, ideally, systematic assessment information relating to health and other barriers would be used to develop fair definitions; the findings in this report could also be used as a basis to expand or refine sanctioning policies.

5. Work-Related Requirements. PRWORA established minimum participation rates and hours of work-related activities for states, and these standards increase over time. In 1998, for example, when data for this study were collected, 30 percent of single parents were expected to be engaged in 20 hours per week in a work-related activity. By 2002, however, 50 percent of the caseload will be expected to participate for 30 hours per week or more in an appropriate activity.[20] However, the findings in this study suggest that recipients remaining on the caseload are increasingly likely to have multiple health and nonhealth barriers to employment and to work-related activities. This means that, if anything, it will be harder rather than easier over time for states to meet the work expectations set forth in the PRWORA legislation. The reasonableness of the established standards should be reconsidered in light of the findings in this report.[21]

Another issue is what to "count" as an allowable activity. An alternative to lowering participation standards might be to allow specialized services that are designed to ameliorate barriers

---

[18] The most frequently cited reasons for the most recent sanction were failure to attend required classes (18.5 percent), failure to keep an appointment or go to a redetermination hearing (15.3 percent), and failure to provide necessary information or turn in paperwork (13.7 percent). It should be noted as well that many former recipients who had left welfare within the previous year had also been sanctioned in the previous 12 months: Sanctions were reported by 35 percent of those in the work-only group and by a full 47 percent of those in the no-work, no-welfare group who had recent welfare assistance.

[19] Certain health-related problems — for example, hearing and vision deficiencies — could also affect clients' comprehension of welfare policies; staff could be sensitized to such factors.

[20] As noted in Chapter 8, among the women in the Urban Change sample who worked, women with health problems were significantly less likely to be working 30 hours or more per week than women without these problems; that is, they were more likely to be working part time.

[21] Participation rates are expected to be adjusted to account for caseload declines, but final regulations pertaining to such adjustments have not yet been issued (Thompson et al., 1998).

(for example, life skills for domestic violence victims, drug rehabilitation programs for substance abusers, and so on) to be treated as participation in a welfare agency's program.

6. Time Limits and Exemptions. The issue of time limits and the possibility of exemptions from them is a critical one in thinking about state welfare strategies and about federal welfare policies. It is an issue of considerable complexity and subtlety.

PRWORA set a 60-month maximum lifetime limit on federal cash assistance, but, in recognition that some recipients will be unable to secure employment within the five-year time frame, the law allows states to exempt up to 20 percent of their average monthly caseload from the time limit by reason of "hardship." The definition of what constitutes a hardship exemption is left up to the states.

The exemption policy essentially creates a three-tiered system for recipients of cash aid. In the first tier are those with severe disabilities who qualify for SSI, according to strict and well-defined criteria. In the second, not-well-defined tier are those who will qualify for an exemption from the time limits under the 20 percent provision. In the third and final tier are all remaining recipients who are expected — regardless of any health problems or other barriers — to leave welfare permanently within five years. Among the pressing questions facing policymakers are the following:

- Is a three-tiered system adequate? Are people in the third tier sufficiently homogeneous that it makes sense to have a uniform policy that applies to all of them?
- Is 20 percent an adequate percentage for those in the second tier? What are reasonable criteria for defining hardship?
- What should be expected of recipients who are exempted?
- What should the relationship be between exemptions from work participation and exemptions from the time limit?

Although the findings from this study do not offer firm answers to these questions, they nevertheless contribute information relevant to their debate.

a. The Three-Tiered System. The findings from this study strongly suggest that "hardship" is better described on a continuum than in discrete categories. At one extreme of the continuum are women who are readily employable and who leave welfare for work with relatively little need for services or support. Women in the work-only group appear to be at this end of the continuum, although many of them also have health problems and other constraints that may make it necessary for them to return to welfare under certain circumstances (for example, worsening economic conditions, a collapse of child care arrangements, aggravated health conditions of a child). At the other end of the continuum are women with severe disabilities who have turned to SSI for cash assistance. Some of the women in the no-work, no-welfare group are at this end. In between are women with problems that vary in type, number, and severity. Except for those who will qualify for an exemption, all these women "in between" will be treated as though they are comparable to the women at the positive end of the continuum — yet they clearly are not. None of the women in the Urban Change sample had reached her time limit when she was interviewed. But, as noted earlier in this chapter, some recipients — especially those in the welfare-only group — appeared at risk of reaching the time limit without being able to secure employment.

It seems possible that the ultimate aims of welfare reform — moving people from dependence to self-sufficiency — could be better served through policies that acknowledge that employability is not dichotomous or trichotomous. Having policies that specifically take the full continuum into consideration may not be practical or politically feasible; nevertheless, some strategies do exist that do not assume that the 80 percent of the nonexempt caseload are homogeneous with respect to employability. For example, in Arizona there is effectively a four-tiered system in which welfare clients who claim a medical hardship or disability can be referred to a Vocational Rehabilitation program operated by the state's Rehabilitative Services Agency, in lieu of participating in the welfare agency's program, being exempted, or being referred to the SSI program (Thompson et al., 1998).

b. The 20 percent Exemption Policy. PRWORA established an exemption policy based on a "best guess" about what an appropriate percentage would be. Based on the data from the 1998 Urban Change survey, it seems possible that more than 20 percent of recipients may need an exemption from the time limit. Here are some possible definitions of "hardship," along with the corresponding prevalence rates among women in this study's two welfare recipient groups:

• Is in fair or poor health	28.5 percent
• Has an unfavorable score (less than 40) on the physical component of the SF-12	27.3 percent
• Is at high risk of depression (CES-D score of 24 or higher)	30.0 percent
• Has a physical or mental health condition that limits the kind or amount of work she can do	28.6 percent
• Health regularly limits her in climbing a flight of stairs	22.9 percent
• Pain interferes with her ability to do work or housework	26.3 percent
• Has one child or more with an illness or disability that makes it hard for her to work	23.1 percent

All these definitions of "hardship" have prevalence rates above 20 percent. Moreover, women meeting one definition are not necessarily the same as those meeting a different definition — for example, women with disabled children are not necessarily the ones who are in poor health themselves — meaning that the prevalence rate of *any* of these conditions would be higher. Indeed, if the multiple health barrier index were used to define hardship, 79.5 percent of the current recipients in the Urban Change sample would have at least one hardship, and half would have two or more. Of course, this sample is not representative of all welfare recipients, and the Urban Change data are nonclinical and therefore have limitations as formal measures of health status. At the same time, however, these hardship estimates are based on *all* recipients. As women in the work-and-welfare group transition to the work-only group — that is, as caseloads decline — the recipients remaining on the caseload are likely to have even higher prevalence rates. What seems clear is that, for public policy purposes, more information is needed on the percentage of the caseload who truly qualify for an exemption. And states might want to consider maintaining a data system with sufficient information to understand the characteristics and barriers faced by their clients.

Under current PRWORA rules, if a state's exemption rate exceeds 20 percent, it can use its own funds to support recipients who need assistance beyond the five-year time limit, and so states will need to develop policies with regard to this option. Exemption policies will undoubtedly also be a subject of discussion in the upcoming debates regarding reauthorization of PRWORA.

c. Expectations for Exempted Recipients. Many women with one health barrier or more *can* work, as discussed in Chapter 8. An exemption from the time limit does not mean that exempted women should not be encouraged to work and not be supported in doing so; it means only that exempted women would continue to receive cash welfare benefits. In fact, exemptions (and similarly, receipt of SSI) without services *could* be construed as a violation of the Americans with Disabilities Act. Categorical exemptions have in the past been a concern of advocates for the disabled because they constitute a disincentive for welfare agencies to work aggressively in serving recipients with disabilities. There needs to be a balance between, on the one hand, onerous work requirements and associated penalties for people with health limitations and, on the other, simply ignoring their needs and "warehousing" them in an unserved category.

d. Coordination of Exemptions. An exemption from participation in work-related activities is not the same as an exemption from the time limits, and it appears that more sensible and cohesive policies need to be developed with regard to how the two interrelate. In a recent analysis of state policies affecting recipients with disabilities, Thompson et al. (1998) found that some states had a policy of exempting such recipients from participation requirements but *not* from time limits. This lack of coordination is a concern because it implies that some people with health problems may not receive ongoing employment services, but they could still face termination from welfare benefits at the end of their time limit.

C. Implications for Other Policies and Programs

Increasingly, policies and programs governing cash aid to welfare recipients interact and intersect with other policy initiatives, requiring coordination at various levels. Examples include policies for such key safety net programs as the Food Stamp Program and Medicaid as well as for employment and training programs, housing, and so on. The next three sections consider some of the implications of the findings in this report for policies and programs other than cash welfare.

1. Food Stamps. Most welfare recipients with multiple barriers will need ongoing public assistance when they enter the labor force — and, of course, they will be in special need if they fail to enter the labor force but are terminated from welfare due to the time limits. As highlighted in the ethnographic findings, food stamps are a critical resource for poor women; yet the current study as well as other studies of welfare leavers suggest that some women who leave welfare also leave the Food Stamp Program, even though they continue to be eligible.

Clearly, steps need to be taken to ensure than women who exit welfare obtain the food stamp benefits for which they are eligible.[22] The steps could include: (1) better training of caseworkers so that they fully understand new eligibility rules and appreciate the importance of consistently and regularly communicating this information to clients; (2) better use of technology to identify qualified welfare leavers who are eligible for food stamps; (3) outreach to notify welfare leavers of their eligibility; (4) more convenient hours and mechanisms for employed people to apply for benefits or get recertified (for example, mail-in recertifications, "one-stop shopping" locations for various services and benefits); and (5) outreach at food pantries and other community agencies that serve the needs of the poor. As noted in Chapter 1, a recent (April 2000) directive from the Health Care Finance Administration provided states with new guidelines designed to curtail improper terminations from Medicaid. Similar initiatives for the Food Stamp Program appear to be warranted.

Another issue that needs to be dealt with more effectively concerns the problems that arise when people who have fluctuating incomes lose and gain eligibility for food stamps (and Medicaid) on a month-to-month basis. Women in low-wage jobs often have schedules that change weekly, or they may have seasonal employment; income may also change frequently because women need to take sick days without pay. Given the precarious financial situations of many of the Urban Change women, problems in obtaining the full food stamp benefits to which they are entitled can pose undue hardships.

2. Health Insurance. As with food stamps, efforts must be made to ensure that women who leave welfare and are eligible for either transitional or noncash Medicaid continue to receive this health insurance coverage. All four Urban Change sites have taken steps within the past year to improve the delivery of transitional Medicaid benefits. It remains to be seen whether these efforts will be successful in eliminating the problems that some women have experienced in losing Medicaid when they leave welfare.

There are other problems, however. Many women who leave welfare and work full-time or near-full-time schedules become ineligible for Medicaid once their transitional benefits are exhausted. Given the health care needs identified in the present study, a critical public policy challenge appears to be the development of mechanisms to ensure that such women have health care coverage once they leave welfare. There are many ways this could be achieved, including incentives to employers, state-funded insurance programs, Medicaid buy-ins, and further expansions of Medicaid eligibility.[23] And while it is laudable that recent initiatives have made an increasingly large number of low-income children eligible for health insurance through Medicaid expansions and the Children's Health Insurance Program (CHIP), the disparity in policies for low-income women and low-income children merits scrutiny. The women in the Urban Change survey sample were less healthy than their children, yet were less likely to have insurance and less likely to have access to health care — even though *they* were the ones who shouldered the responsibility for raising and supporting their children. Welfare leavers who lack health insurance will be forced either to forgo health care, if they cannot afford it, or to find care from a diminishing supply of safety net providers.[24]

---

[22] Quint and Widom (2000) discuss this issue in detail.

[23] Of course, universal health insurance is another policy option, but one that does not seem politically viable at present.

In this study, former welfare recipients in the work-only group who lacked health insurance could be described as women who had played by the rules and yet lost ground. Under current policies, women with health problems might be better off not working (or working only part time or in the underground economy) after they hit the time limits, simply to retain Medicaid benefits. For women with multiple health barriers, Medicaid is far more valuable than cash aid. Incentives need to be structured to ensure that women are encouraged to work the number of hours that are compatible with their skills and limitations, without fear of losing health insurance.

It is important to note that many of the goals and objectives of Healthy People 2010 (the national initiative for establishing and monitoring health priorities for the upcoming decade) are likely to be attainable only if efforts are made to address the needs of the Urban Change and other disadvantaged populations. The Healthy People initiative establishes benchmarks for a variety of health indicators, and it seeks to achieve specific, measurable improvements — improvements that are most likely to be attained among the poor, since there is less room for improvement among the more affluent. One of the leading health indicators for Healthy People 2010 is access to health care, and specific objectives include increasing the proportion of people with health insurance and increasing the proportion of people with a specific source of ongoing health care over the next 10 years (U.S. Department of Health and Human Services, 2000a). If welfare reform succeeds in moving large numbers of welfare recipients into jobs — many of which will not offer health benefits — it is possible that the proportion of people who are uninsured and have health care access problems will actually increase, unless new health policies are enacted.

3. Welfare-to-Work Grants Program. The Welfare-to-Work (WtW) Grants Program, authorized under the Balanced Budget Act of 1997, provides funds to be distributed to local employment-focused programs through the U.S. Department of Labor. These grants are designed to assist the most disadvantaged welfare recipients[25] in moving from welfare to work, through work-related activities. Congress authorized $1.5 billion for this program for both FY 1998 and 1999, but for a variety of reasons program enrollment and spending were lower than anticipated. Some commentators have argued that the stringent eligibility criteria were a major factor contributing to low enrollments. According to the original legislative provisions, 70 percent of all WtW grant funds were to be spent on long-term recipients (30 months or more of receipt) or on those who were within one year of the TANF time limit *and* who had two of three specified barriers (no diploma or GED certificate, substance abuse problems, and a poor work history). The remaining 30 percent of funds could be spent on recipients who had characteristics associated with long-term dependence, such as being a high school dropout or a teenage parent. However, programs were reluctant to enroll people under the 30 percent criterion because they were unsure that they would find enrollees who would meet the tight 70 percent criterion (Nightingale, Trutko, and Barnow, 1999).

---

[24] The number of safety net providers who offer free or low-cost health care to the indigent is diminishing at a time when demand is increasing as a result of rising rates of uninsured people. There is some evidence that the penetration of Medicaid managed care is related to the availability of such providers (Cunningham, Grossman, St. Peter, and Lesser, 1999).

[25] WtW grants can also be used to serve noncustodial parents of welfare children, to enhance their ability to pay child support.

In recognition of these problems, the 1999 WtW amendment removed the requirement that long-term recipients also have two of the three specified barriers to employment. Currently, 70 percent of the grant funds are earmarked for TANF recipients who have received welfare for 30 months or more, are within 12 months of their time limit, or have reached the time limit without employment. It is too soon to determine whether the amended criteria will result in full enrollment in WtW-funded programs. If enrollment problems persist, it could be argued that the 70 percent funds be allocated using the multiple barrier criterion — adding other barriers such as domestic violence and mental health barriers to the list of three in the original legislation — *in lieu of*, or in addition to, the criterion based on long-term dependence and time limits.

The findings from the current report also are relevant immediately with regard to the 30 percent funds. Under the amendment, TANF recipients qualify for the 30 percent slots if they have "significant barriers to self-sufficiency" under criteria established by local Private Industry Councils (PICs). The health and mental health barriers to employment that are identified in this report could be used to guide the development of those criteria.

VI. Conclusion

It seems clear that, as public policymakers head toward decisions about the reauthorization of PRWORA and about provisions and programmatic features that can improve the success of this legislation, the health and health care needs of welfare recipients in urban areas will need to be taken into consideration.

In concluding, it is also important to remember that the findings in this report are based on data obtained at a time of unprecedented economic growth. In all policies arenas relating to public assistance, it is critical not only to anticipate the inevitability of an economic downturn but also to take employment barriers into account in planning for such a downturn. In the strong economy of recent years, one barrier or even two or more may not exclude recipients from the labor market — especially if they have certain enabling characteristics that make them more attractive to employers. However, in a less favorable economy, employers can be more selective in hiring — and less cautious about firing — their employees. In such an economic climate, women with even one health or other barrier may find it substantially more difficult to transition from welfare to work, and to sustain jobs, than the women in the Urban Change sample. Anticipating such change could lead, for example, to conditional policies that tie the unemployment rate to various provisions of the legislation, such as the rates of exemptions and the time limits themselves.

Appendix A

Response Rates and Response Bias in the Urban Change Survey Sample

I. Response Rates

Using administrative records from the four Urban Change sites, the survey sample was randomly selected from women who, in May 1995, were food stamp and/or welfare recipients in the Aid to Families with Dependent Children (AFDC) program and who met other sampling criteria. Specifically, the study population consisted of women who in May 1995 were age 18-45; had one or more children living at home; were not married; and resided in a census tract that had high rates of poverty in 1990 (30 percent of the residents or more) or high rates of welfare receipt in 1995 (20 percent of the residents or more). Additionally, to be eligible for the sample, the women had to speak either English or Spanish. Across the four sites, 5,041 eligible women were sampled.

The targeted sample size was 1,000 completed interviews per site, and the targeted response rate was 80 percent of those sampled. Although a higher response rate would, of course, have been desirable, several factors made achieving even an 80 percent response rate a formidable goal. First, there were no "baseline" data from 1995 — such data are often available in demonstration studies — and therefore there was no contact information other than the women's 1995 address from welfare agency records (for example, no information about the names and addresses of others who might know the women's whereabouts). Second, welfare recipients are a highly mobile population, and therefore many would have moved one time or more since 1995. This was considered a particular problem regarding women not born in the United States, who sometimes move not only to another part of the city but out of the country altogether. Third, between the "baseline date" of May 1995 and the date of the interview, over three years elapsed (39.0 months, on average). Women who continued to receive public assistance in the sites where they were sampled were easier to locate than those who did not, because more up-to-date address information was available for them from welfare agency records. However, for women who had left public assistance, the address information was often two to three years old. Moreover, with the introduction of electronic benefit transfer (EBT) systems for food stamp recipients, there is less incentive to keep address information accurate. Finally, the four sites are all large urban areas where people are sometimes wary and reluctant to open their doors to strangers.

Despite these challenges, Temple University's Institute for Survey Research (the survey contractor) was able to achieve an overall response rate close to the targeted rate: 78.6 percent. Of the 5,041 potentially eligible women in the original sample,[1] a total of 3,960 were interviewed. As shown in Figure A.1, some 9.4 percent of the sampled women could not be located, and 9.7 percent were located but refused to be interviewed. The remaining 2.3 percent of the

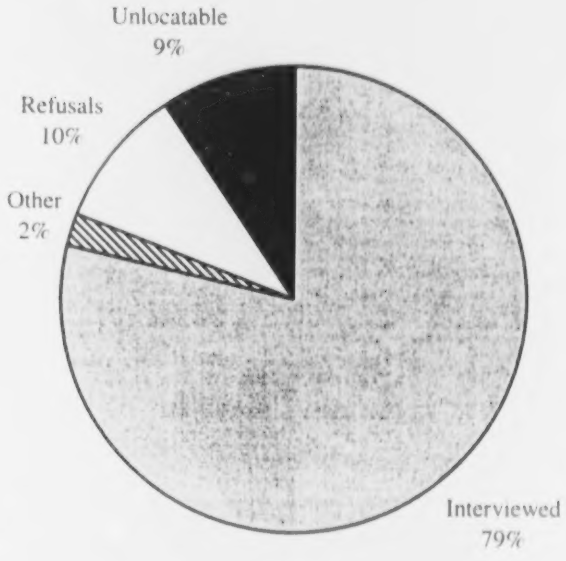
---

[1] Although the selected sample met all the basic eligibility criteria, it could not be determined from administrative records whether sample members could speak English or Spanish. This was established by the interviewers after the sample member was located. Thus, some of the women who were unlocatable might not have been eligible, based on their language abilities.

The Project on Devolution and Urban Change

Figure A.1

Urban Change Respondent Survey Sample Disposition[a]



SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE: [a]Of 5,041 eligible respondents sampled.

original sample members were not interviewed for various reasons, such as mental or physical incapacitation, or the fielding period having ended before an interview could be secured. Response rates in the four sites were as follows: Cleveland, 80.0 percent; Los Angeles, 75.6 percent; Miami, 78.7 percent; and Philadelphia, 80.0 percent.

II. Response Bias: Survey Respondents and Nonrespondents

An important question is whether the 21.4 percent of the sample who were not interviewed were a random subset of the entire original pool. Response bias could potentially operate in two competing directions. On the one hand, it is plausible that a disproportionate number of women who were not interviewed were especially advantaged. For example, women who had left welfare and were also no longer receiving food stamps would presumably have been more difficult to find because the welfare agency would no longer have their addresses. Locating such women would be very difficult if they had married and changed their name or if they had moved away from the area due to employment or marriage. On the other hand, it is also plausible that the most highly *dis*advantaged women would have proved difficult to locate or to interview. It would presumably be particularly challenging to trace, for example, women with a high rate of residential instability and homelessness, with fewer roots in the community, and with a history of institutionalization (for example, in jails, mental hospitals, or drug rehabilitation programs). Moreover, women who avoided contact because of criminal or fraudulent activity, or who feared deportation for themselves or other family members, might have been especially unwilling to be interviewed.

Unfortunately, the data available for analyzing response bias are, at this point, extremely limited. Information about only a handful of population characteristics was available in the administrative records, and the information varied from site to site. (Eventually, there will be historical information about welfare receipt and earnings going back to 1992, which will permit a more powerful analysis of response bias.)

Information on two characteristics of the selected sample members was available across all four sites: age and race/ethnicity.[2] With data from all four sites pooled, age was not significantly related to the likelihood of responding to the survey, but race/ethnicity was: Even after controlling for site in the logistic regression analysis, whites who were sampled were significantly less likely and African-Americans were significantly more likely to have been interviewed. However, the differences between responders and nonresponders were not sizable. For example, 69.9 percent of survey respondents were African-American, compared with 64.1 percent of nonrespondents. *Among the women actually interviewed*, African-Americans were better educated than women of other racial/ethnic backgrounds, suggesting the possibility that better-educated women might have been somewhat overrepresented in the survey — although the educational attainment of the nonrespondents is, of course, unknown.

Information about the number of children in the household in May 1995 was available for three sites: Cleveland, Los Angeles, and Miami. In logistic regression analyses using data from these three sites, race/ethnicity continued to be significant, and number of children in the household was also significant. Respondents had significantly *more* children, on average, than nonrespondents, but again the differences were not large. The average number of children among respondents was 2.2, and the average number among nonrespondents was 2.0. Among the survey respondents, women with more children tended to be somewhat *less* advantaged than those with fewer children (for example, number of children was negatively correlated with total family income), suggesting the possibility of a bias in the opposite direction — that is, toward respondents being *less* advantaged than nonrespondents.

---

[2] By design, all sample members were AFDC/food stamp recipients. Therefore, nonrespondents were no more likely than respondents to be public assistance recipients.

Overall, these response bias analyses do not indicate a strong or discernible pattern in a consistent direction. Further analyses also suggest that the original expectations might be supported — namely, that response biases run in opposite directions. It was reasoned that the women who were interviewed in the last few months of the fielding period would be more like the nonrespondents than those who were interviewed earlier. That is, the women who were the hardest to find or the least readily willing or available to be interviewed were expected to be interviewed late in the fielding period. (If the fielding period had been extended, it is likely that some of the nonrespondents would have been interviewed.) Therefore, analyses were run to examine respondents' characteristics in relation to their date of entry into the interview sample.[3] Overall, there were a very large number of significant differences, and the differences are consistent with the prediction that both the most and the least disadvantaged women had a tendency to enter the sample late. First, consistent with data available for the "real" response bias analysis, women with fewer children had significantly longer intervals between May 1995 and the date of the interview, suggesting that the line of reasoning in performing these interval analyses had some merit. Additionally, the interview date was significantly *later* for women living with a husband or partner, women in the work-only group, women who were food secure, women who had no material hardships, and women with higher incomes — all of which imply that women who entered the sample late were better off than those who entered earlier. On the other hand, there was also a significantly longer interval for women who were noncitizens and who had three or more structural barriers to employment, suggesting somewhat higher levels of disadvantage among some later entrants.

In conclusion, both types of response bias analyses suggest that survey respondents were not a random sample of women who were selected from administrative records. However, the biases generally do not seem sizable, and they appear to have operated in competing directions, possibly neutralizing some of the effects of these biases on the findings presented in this report.

III. Other Types of Response Bias

In addition to the patterns of nonresponse for the overall survey, two other types of analyses were undertaken: a comparison of respondents who did and did not complete the self-administered questionnaire (SAQ) portion of the survey; and a comparison of respondents who did and did not provide sufficient information to compute total household income.

---

[3] The variable indicating the time elapsed between May 1995 and the interview date was controlled in the regression analyses predicting health outcomes and was almost always statistically significant. See Appendix E.

A. SAQ Response Bias

Many of the key outcomes presented in this report were derived from a portion of the interview that was self-administered in paper-and-pencil format, rather than being asked orally in interview format through computer-assisted personal interview (CAPI) procedures. The decision to use an SAQ was based on the expectation that respondents would be more candid in response to personal questions about depression, life stresses, domestic violence, substance abuse, and personal health limitations if they could provide the information privately.

Some respondents, however, did not complete the SAQ: 45 refused, and another 45 apparently agreed to do it but left the SAQ blank. These 90 women were compared with the other women in the sample in terms of background characteristics and other health-related variables measured in the main CAPI survey. Of more than 30 analyses conducted, only one was statistically significant. SAQ completers and noncompleters were comparable in terms of site, age, race/ethnicity, educational attainment, citizenship status, marital/partner status, total family income, food security, housing problems, obesity, and insurance status. Therefore, nonresponse to the SAQ does not appear to have biased the findings summarized in this report.

B. Total Household Income Response Bias

Altogether, it was not possible to compute total family income for 374 survey respondents — roughly 10 percent of the sample. A few outcomes in this report (for example, worst-case housing needs, food expenditures as a percentage of income) required total income information, and therefore it was considered important to examine whether there might be response biases in responses to income questions.

There were a number of significant differences between respondents for whom total household income was and was not available, and in general the pattern suggests that those for whom the data were missing were more economically advantaged than those for whom the data were complete. Women *without* total household income information were, compared with women with complete household income data, more likely to have a high school diploma or GED certificate, be a U.S. citizen, have no structural barriers to employment, be food secure, live in a good neighborhood, be at low risk of depression, and not live in public housing — all of which are correlated with household income. These women were also more likely to have left welfare — that is, to be in the work-only group or the no-work, no welfare group. Of particular note is that they were especially likely to be living in larger households — and to have family members with a source of income they could not (or would not) estimate.

Thus, the analyses in this report are likely to somewhat (1) overestimate the overall sample's level of disadvantage in terms of variables like worst-case housing needs and food expenditures as a percentage of income and (2) underestimate differences between welfare recipients and nonrecipients on these variables.

Appendix B

Defining the Four Work/Welfare Research Groups

Considerable thought was given to the issue of how best to define the women's work/welfare status for the main analyses presented in this report. The central issue concerned whether (and how) to address the fact that, in this population, there is considerable movement on and off welfare and in and out of employment — that is, "churning." The deliberations focused on whether the definition should be based on (1) current status, (2) stability in status over a designated period of time, or (3) some combination of the two. Ultimately, it was decided that the most defensible definition would be to base the classification on the women's status at a fixed point in time (that is, the time of the interview),[1] despite the fact that such a definition would mask some "noise" resulting from classification instabilities. The decision was based on several considerations, which are summarized below.

I. Nature of the Health Outcomes

One definition of the four work/welfare groups that was considered was based on the women's overall labor force attachment. This approach would have included in the two employed categories only those women who had worked for some minimum number of months within a fixed time frame (for example, at least 6 of the past 12 months), regardless of whether they were currently employed. However, many of the critical health outcomes available in the survey were measures of *current* status that were most likely to be associated with current employment and welfare status. For example, current health insurance coverage of a woman and her family is more likely to be linked to current employment and welfare status than to employment *history*. If a woman worked 9 of the past 12 months in a job with health insurance benefits but is currently unemployed and has no benefits, her previous job stability would bear no relation to her health coverage. Similarly, if depression is linked to work status (for example, a woman may be less depressed if work enhances her self-esteem, or may be more depressed if she is anxious about her children while she is away from home), the link would likely relate to *current* status, rather than to whether the woman worked 9 of the past 12 months. Thus, given the nature of many of the key health outcomes, it seemed important to use information about current employment in the definition of work/welfare groups.

---

[1] Specifically, for the purpose of this report, a woman was considered employed if she answered "yes" to the following question: "Are you *currently* working at any regular or odd job for pay?" Respondents were asked this question only if they answered affirmatively to one of two questions that explained to them the criteria for employment. First, women were asked, "Since [date two years prior], have you worked for pay at a regular job at all? Please don't count unpaid work experience, but do include any paid jobs, including paid community service jobs or paid on-the-job training." Second, respondents who said "no" were probed with the following question: "A lot of people have irregular or temporary jobs on the side to make ends meet. This would include odd jobs like babysitting, doing hair, or other paid work at home, or other occasional jobs like cleaning houses or doing day labor. Have you done any jobs like that for pay since [two years prior]?" A woman was considered to be a welfare recipient if she answered "yes" to the following question: "Are you (or your son/daughter/any of your children) receiving cash welfare benefits right now?"

II. Sample Size Constraints

Consideration was given to using both *current employment* and *employment stability* in the definitions of the work/welfare groups, which would have required creating eight rather than four subgroups. However, this would have resulted in small subgroup sizes for certain combinations. For example, consider subgroups based on the following three criteria: current employment status (employed versus not employed), employment stability (worked at least 6 of the past 12 months versus worked less than 6 months), and current welfare status (on welfare versus not on welfare). Based on such a classification scheme, there would have been only 69 women in one cell (those not currently employed nor on welfare, but who had worked at least 6 of the past 12 months) and 117 in another (those currently not employed who had worked at least 6 of the past 12 months and *were* on welfare). By contrast, other cell sizes would have been quite large. For example, there were 1,288 unemployed welfare recipients who had not worked 6 of the prior 12 months. Thus, both the small sample size of certain cells and the disparity in the size of subgroups led to the conclusion that using eight groups was not workable.[2]

III. Incomplete Historical Information

Another issue concerns the information available in the survey database. The survey collected complete employment histories for jobs held during a two-year period prior to the interview. However, comparable information about welfare history was not obtained. (Questions about start and stop dates of welfare receipt were not included in the survey because, eventually, this information will be available from administrative records. However, this information was not available at the time this report was prepared.) Thus, any definition of the groups based on "stability" would have necessarily referred only to employment stability, not to duration of welfare receipt.

IV. "Noise"

A number of analyses were undertaken to determine both the extent of noise relating to current status and the effect of any noise on the conclusions reached.

A. The Extent of Noise

Despite the fact that women who are or were welfare recipients have been found in other studies to have a relatively high rate of "churning" (moving in and out of the labor market and on and off welfare), there was a fairly high degree of employment stability in the Urban Change survey sample. As shown in Table 2.5 (Chapter 2), the majority of women who were employed at the time of the interview had been in their current job more than 12 months (54 percent). Fewer than one out of six employed women (17 percent) had been in their current job for less than three months, and under 5 percent had held their current job for less than one month. Thus, defining the four work/welfare groups on the basis of tenure in their current job would not have resulted in groups substantially different from those based on the simpler definition of current status. For example, when the work, no-welfare group is defined on the basis of current status only, 1,240 women qualify. When this group is defined in terms of working in a current job for at least three months, 1,072 women qualify. In other words, 86 percent of the women classified in this group on the basis of current employment status would be in the same group even when job stability is included in the definition.

---

[2] Using eight subgroups based on current employment status, employment stability, and current welfare status was problematic for two additional reasons: (1) effective communication would be curtailed because, with eight groups, the tabular material would be very complex, and it also would be difficult to characterize the eight groups simply and clearly in the text; and (2) clear-cut trends across health outcomes for eight groups seemed unlikely, which would make it more difficult to discern important and consistent patterns.

Also of concern was the possibility of creating a different type of noise or, simply, of shifting noise from one group to another. If, for example, women were classified as "employed" only if they had held their current job for at least one month, this would reduce noise in the two groups of women who worked (that is, the women would be classified as workers only if they demonstrated a minimum level of attachment to their jobs). However, this would create greater noise in the two nonworking groups, because *these groups would actually include women who were currently working* but who began their current job fairly recently. This can be most clearly illustrated by considering information in Table 2.4 (Chapter 2), which shows selected characteristics of women in the four research groups. Using current status to create the groups, the table shows that 27.3 percent of the nonworking current recipients, and 38.2 percent of those who neither worked nor received welfare, did hold a job at some point in the prior 12 months. In other words, these people had "churned" and would have been classified in a different category had they been interviewed at a different point in time. However, by changing the group definition to include the criterion that the current job be of at least one month's duration to qualify the person as employed, the noise would be even greater. For example, with this definition, 44.9 percent of the women in the no-work, no-welfare group (compared with 38.2 percent) would then be described as having worked in the prior year — because, actually, they were *currently* working at the time of the interview, despite their inclusion in a nonworking group.

B. The Effect of Noise

A number of analyses were undertaken to determine whether a definition of employment that incorporated information about job stability would change the conclusions presented in this report. Table B.1 summarizes some of the results. In this table, the four work/welfare groups are defined three different ways on the basis of the following criteria (indicated by 1, 2, and 3 in the table):

1. Current welfare receipt (yes/no) and currently employed (yes/no) — that is, exactly as defined in this report
2. Current welfare receipt (yes/no) and currently employed in a job for one month or more (yes/no)
3. Current welfare receipt (yes/no) and currently employed in a job for three months or more (yes/no)

Several aspects of Table B.1 are worth noting. First, *with rare exception, the findings are consistent across definitions.* That is, no matter how the groups are defined, the level of significance remains the same, and, except for one or two instances where the differences between two groups were negligible, the ordering of the groups on the various health outcomes remains the

The Project on Devolution and Urban Change

Appendix Table B.1

Selected Health Outcomes, by Work and Welfare Groups Defined Three Ways[a]

Outcome (%)	Definition[b]	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Food secure[c]	1	51.2 ***	58.1	50.5	47.5	44.6
	2	51.2 ***	58.5	50.0	47.8	44.6
	3	51.1 ***	59.0	49.4	48.1	46.4
Has less than 3 material hardships[d]	1	28.2 ***	19.4	26.1	35.5	31.4
	2	28.2 ***	19.0	26.8	35.0	31.2
	3	28.2 ***	18.9	28.2	34.0	29.1
Currently smokes	1	39.8 ***	32.2	39.9	44.9	44.1
	2	39.8 ***	32.0	39.6	44.9	43.8
	3	39.8 ***	32.0	39.6	44.5	41.4
Average SF-12 score[e]	1	46.9 ***	49.1	48.0	45.2	44.7
	2	46.9 ***	49.1	47.9	45.2	45.1
	3	46.9 ***	49.0	47.8	44.5	46.1
CES-D score less than 16[f]	1	49.7 ***	40.1	48.8	56.9	54.8
	2	49.8 ***	39.5	48.8	56.8	55.5
	3	49.8 ***	39.3	48.7	56.3	52.5
No health insurance, prior month	1	19.5 ***	33.6	6.1	6.2	44.5
	2	19.5 ***	33.0	6.4	6.0	45.4
	3	19.5 ***	31.6	6.1	6.1	45.5
Needed a doctor but couldn't afford one	1	23.4 ***	32.4	13.9	15.9	39.5
	2	23.4 ***	31.7	14.4	15.0	40.9
	3	23.4 ***	31.8	14.9	14.8	39.0
Regular source of health care	1	88.9 ***	85.4	91.4	92.9	81.8
	2	89.0 ***	86.0	91.5	92.8	81.1
	3	89.0 ***	86.4	91.4	92.7	81.3
Child with health problem that limits mother's work	1	19.8 ***	13.1	18.6	25.0	23.1
	2	19.8 ***	13.3	18.6	24.8	21.8
	3	19.8 ***	12.8	19.0	24.3	20.9
Sample size	1	3,764	1,240	626	1,467	431
	2	3,746	1,191	590	1,497	468
	3	3,746	1,072	477	1,610	587

(continued)

Appendix Table B.1 (continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] Definitions of outcomes are presented in the text: food secure, material hardships (Chapter 3); currently smokes, SF-12 physical component scores (Chapter 4); CES-D scores (Chapter 5); health insurance and health care access (Chapter 6); and child with a health problem (Chapter 7).

[b] Groups were formed using the following definitions of welfare and employment status:

1 = current welfare receipt (yes/no) and current employment status (works/doesn't work) -- that is, as in the text of the report

2 = current welfare receipt (yes/no) and currently employed in a job for one month or longer (yes/no)

3 = current welfare receipt (yes/no) and currently employed in a job for three months or longer (yes/no)

[c] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[d] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[e] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[f] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

same. Second, for all outcomes, the actual values are similar across all three definitions.[3] The group with the most sizable changes is the no-work, no-welfare group, whose small sample size leaves it most vulnerable to change based on different definitions. And third, the changes are not always what one might predict, suggesting that some of the change reflects random fluctuation rather than systematically capturing an important construct. That is, one would expect increasingly better outcomes for working women as employment stability increases. In some cases this does occur, particularly among working women who were not welfare recipients. For example, slightly improved outcomes are observed for the group of working former recipients as job tenure increases in terms of food security, multiple material hardships, and depression. However, among the working welfare recipients, food security actually decreased slightly, and material hardships increased with increased job stability. Taken together, this evidence suggests that using an alternative definition of "employment" would not have affected any of the conclusions reached in this report.

V. Comprehensibility

Another less critical consideration — but one that is consistent with the ultimate decision — is that a definition of the research groups based on current status is easy to understand and easy to communicate. That is, at a fixed point in time (when they were interviewed), the women either were or were not working. Relatedly, this definition is easier to communicate because it does not require qualifiers. For example, the employed former recipients can be described as such, without having to qualify this repeatedly by saying "former recipients who had been working at least three months in their current jobs."

In conclusion, the decision to define the four research groups based on current employment and welfare status was based on several considerations. The particularly important factor was that other definitions did not change the basic findings of the report.

---

[3] The figures shown in Table B.1 are unadjusted. When statistical controls for background characteristics are included, the differences among the three definitions are even smaller.

Appendix C

Site Differences in Sample Characteristics and Health Outcomes

As noted in Chapter 2, the four Urban Change research sites are large urban areas that vary considerably in terms of demographics, the local economy, and public welfare policies. This appendix summarizes differences among the sites in the characteristics and health outcomes of women in the survey sample. First, some background characteristics are presented, by site. Then, for each substantive chapter of the text (Chapters 3-8), there is a corresponding table with key outcomes. Finally, several critical health outcomes are presented, by work/welfare status, for each of the four sites.

I. Background Characteristics

Survey respondents in the four Urban Change sites were different in a number of important respects, as shown in Table C.1. The most prominent differences related to the race/ethnicity of the respondents and their citizenship status. Overall, only 5 percent of the survey sample are white,[1] with the highest percentage in Cleveland (11.7 percent). The majority of women in all sites are African-American, but there were sizable percentages of Hispanics in Los Angeles (42.4 percent) and Miami (31.8 percent). In both these sites, about one out of five survey respondents were noncitizen immigrants. Women in these two sites were also most likely to say that they had difficulty understanding spoken English — about one out of seven women in Los Angeles reported such a language barrier.

The majority of women in all four sites were single mothers with one child or more living with them. Women in Los Angeles and Miami were more likely than women in the other two sites to be currently married, although the women in all sites were similar in terms of living with *either* a husband or a partner. Overall, about 20 percent of the sample were either married or cohabiting at the time of the interview.

There were no significant site differences in such characteristics as number of children in the household and number of household members. On average, the women had 2.4 children living at home. Just under half the women in all sites had at least one child under age 6 living with them; the average age of the youngest child was highest in Philadelphia. In all four sites, about 4 percent of the women were pregnant at the time of the interview.

Education differences among respondents in the four sites were substantial. Women in Los Angeles were especially disadvantaged in terms of education credentials: Over half did not have a high school diploma or GED, and only 16 percent had any college credits. Women in Cleveland had the best credentials: About 60 percent had a diploma or GED, and nearly one-quarter had some college credits.

---

[1] Whites are underrepresented in the survey sample, relative to their representation in the welfare population of the four sites, most likely as a result of the fact that survey respondents were sampled from census tracts with high concentrations of poverty and welfare receipt. Table 2.2 of Quint et al. (1999) presents the racial/ethnic composition of TANF recipients for the sites overall.

The Project on Devolution and Urban Change

Appendix Table C.1

Selected Characteristics of the Urban Change Respondent Survey Sample, 1998-1999, by Site

Characteristic	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Average age	33.7	33.2	34.0	33.6	33.8
African-American (%)	68.3 ***	79.8	52.4	65.1	74.8
Hispanic (%)	24.5 ***	7.0	42.4	31.8	18.2
White, not Hispanic (%)	5.4 ***	11.7	2.1	2.2	5.2
Not a U.S. citizen (%)	9.7 ***	0.2	21.5	17.8	0.6
Has trouble understanding spoken English (%)	7.2 ***	0.9	13.4	12.2	3.2
Married, living with spouse (%)	8.8 *	8.8	10.4	9.5	6.6
Living with partner, unmarried (%)	10.1 *	11.2	8.7	8.5	11.7
Average household size	4.4	4.2	4.3	4.4	4.6
Average number of own children in household	2.4	2.4	2.5	2.5	2.4
No children in household (%)	4.1	4.8	4.0	3.3	4.3
Average age of youngest child	6.7	6.6	6.4	6.8	7.0
Child under age 6 in household (%)	47.1	48.8	49.7	45.1	44.9
Currently pregnant	3.7	4.1	3.5	3.4	3.7
Does not have a diploma or GED (%)	45.8 ***	39.5	52.4	46.5	45.2
Has a GED or high school diploma (%)	36.1 **	37.2	31.5	36.9	38.6
Has some college credit (%)	18.1 ***	23.3	16.0	16.6	16.3
Never worked for pay (%)	8.0 ***	4.6	10.0	7.5	10.2
Ever employed, past 12 months (%)	65.5 ***	71.4	61.7	66.7	62.2
Currently employed (%)	50.8 ***	55.5	48.6	53.0	46.4
Currently receiving welfare (%)	67.7 ***	66.3	76.4	59.1	68.8
Average household income, past month[a] ($)	1,276.28 ***	1,313.49	1,384.99	1,196.64	1,206.16
Sample size	3,771	970	920	898	983

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Total monthly income includes family income from all sources (earnings, welfare, food stamps, child support, and so on) but does not include income derived from the Earned Income Tax Credit (EITC). Therefore, income is underestimated for many of those working.

Consistent with their relative advantages educationally, Cleveland respondents were most likely to have ever worked for pay, to have worked at any point in the previous year, and to be working at the time they were interviewed (53.9 percent), although Miami respondents were not far behind in current employment (51.3 percent). Women in Cleveland were also more likely than women in other sites to be working full time: Among those working at the time of the interview, 78.2 percent in Cleveland worked 30 hours or more per week, compared with 66.0 percent at the other extreme in Los Angeles (not shown in table).[2]

Table C.1 indicates that just over half the women in the Urban Change survey sample were still receiving welfare benefits at the time of the interview (55.6 percent).[3] Welfare receipt was highest in the two sites where employment rates were lowest: 57.0 percent of the women in Philadelphia were current welfare recipients, and nearly 70 percent of those in Los Angeles were receiving cash welfare benefits. Only in Miami had more than half the women (54.8 percent) left welfare. This is consistent with the fact that, since the 1996 passage of welfare reform, caseloads have declined more sharply in Florida than in other states involved in the Urban Change study.[4]

On average, women in the Urban Change survey sample had a total family income of $1,276 per month (including food stamp benefits), annualized to be just over $15,000 per year. Table C.1 shows that the average family income in the month prior to the interview was higher in Los Angeles than in other sites — possibly because welfare benefits were highest there (see Table 2.1, Chapter 2). Women in Miami had the lowest average monthly family income, consistent with the fact that Florida had the lowest welfare benefits of the four sites *and* the lowest average hourly wage among women who were working (not shown).

In summary, it appears that the women in Cleveland were somewhat less disadvantaged than women in other sites. On average, they had the highest educational attainment, they were most likely to be employed, and they were most likely to have jobs with fixed schedules and fringe benefits.

---

[2] Moreover, employed women in Cleveland were most likely to have a fixed work schedule (72.7 percent) and to have at least one fringe benefit (61.3 percent). Half the workers in Cleveland had employer-provided health insurance, compared with only 36.3 percent of the workers in Los Angeles. However, the average hourly wage among employed women was higher in both Philadelphia ($7.78) and in Los Angeles ($7.70) than in Cleveland ($7.53); it was lower only in Miami ($7.27).

[3] There were sizable site differences among current welfare recipients with respect to their experiences with the welfare agencies. In general, recipients in Cleveland appeared most knowledgeable about new welfare rules and most positive about interactions with caseworkers. For example, over 40 percent of recipients in Cleveland said that they had personalized attention from the welfare staff, had been urged to get further education or training; and had been helped with personal problems that made participation difficult. In other sites, the percentages were generally around 25-30 percent. Also, fewer of the current recipients in Cleveland said that they had been sanctioned in the past 12 months (22.3 percent, compared with nearly one-third in the other three sites). Recipients in Los Angeles were least likely to report that they were subject to a participation requirement or that they were already working (53.1 percent, compared with 66.5 percent in Miami); were least likely to say that they knew about the time limits (61.5 percent, compared with 88.5 percent in Cleveland); and, among those who knew about the time limit, were most likely to say that they did not know how much time was left on their time-limit clocks (32.9 percent, compared with 14.2 percent in Cleveland).

[4] Between August 1996 and August 1998 (roughly the midpoint of when the survey data were collected), the caseload decline was 53.6 percent in Florida (the sixth-highest decline in the United States), compared with 24.4 percent in California (U.S. General Accounting Office, 1999).

II. Material Hardships

Table C.2 presents information about how the sites differed with regard to key measures of material hardship — that is, outcomes described in Chapter 3. As the table indicates, site differences were sometimes significant and sizable, but no one site stood out sharply as having the worst material hardships across domains. Respondents from Cleveland fared better than those from other sites with regard to housing costs as a percentage of their income, but they had one of the highest rates of neighborhood problems, such as vandalism, abandoned buildings, and so on. Los Angeles respondents were most likely to be food insecure and to have high housing costs but were least likely to have neighborhood problems. In Miami, women were especially *un*likely to have multiple housing problems, but they had a higher-than-average rate of food insecurity and the highest rate of utility shutoffs. Women from Philadelphia were the most food secure,[5] but they had the highest rate of neighborhood problems and were most likely to have witnessed a violent crime in their neighborhoods.[6] Women in all four sites had similar rates of homelessness.

Despite the site differences in individual hardship indicators, the women in the four sites were reasonably similar in experiencing multiple material hardships. Although site differences were statistically significant, with Philadelphia having a higher rate than the other three sites, approximately one out of four women in all four sites had three or more of the eight hardships included in the material hardship index.[7]

Table C.2 also shows that the majority of women in all four sites participated in the Food Stamp Program, which is designed to minimize food hardships in low-income families. The sites with the highest percentages of food stamp recipients (Los Angeles and Philadelphia) were also the sites with the highest percentages of TANF recipients. Despite the fact that Miami had the highest rate of welfare exits of the four sites, it was Cleveland that had the highest rate of food stamp exits, perhaps reflecting the fact that women in Cleveland had higher incomes (although Cleveland had the highest rate of using food pantries).[8]

---

[5] The site differences in food security from the Urban Change survey are consistent with state differences, based on data from national surveys. Pennsylvania has one of the lowest rates of food insecurity in the nation (7.1 percent), and Ohio's rate (8.5 percent) is also significantly below the national average of 10 percent. By contrast, both Florida (11.5 percent) and California (11.4 percent) have significantly higher-than-average rates of food insecurity (Nord, Jemison, and Bickel, 1999).

[6] This is consistent with the fact that, using citywide data from the Neighborhood Indicators component of the Urban Change project, the homicide rate is substantially higher in Philadelphia than in the other three sites (see Table 2.3, Chapter 2).

[7] Site differences in having multiple material hardships, though modest, did persist even when the women's race/ethnicity, number of children, partner status, and work/welfare status were controlled, as shown in Appendix Table E.1.

[8] Among women who were no longer welfare recipients, there were substantial site differences that are not reflected in the table. Welfare leavers from Miami were especially likely to still be getting food stamps (45.9 percent), and leavers from Los Angeles were especially *un*likely to be food stamp recipients (15.7 percent). Across all four sites, just over half the former welfare recipients who had also left the Food Stamp Program appeared to be income eligible for food stamps.

Appendix Table C.2

Selected Material Hardship,[a] by Site

Outcome (%)	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Food insecure[b]	48.8 ***	45.1	56.3	53.8	41.0
Received emergency food, prior month	5.2 ***	8.6	4.7	4.9	2.7
Family member received food stamps, past month	69.1 **	64.7	70.8	68.6	72.3
Housing expenditures greater than or equal to 50 percent, prior month[c]	29.6 ***	24.5	39.9	25.7	28.1
2 or more housing problems[d]	25.5 ***	23.5	24.6	21.8	31.8
Gas or electricity turned off 1 or more times, past 12 months	13.5 ***	13.1	10.6	20.6	10.4
2 or more neighborhood problems[e]	46.8 ***	52.2	32.7	36.0	64.6
Respondent or child witnessed a violent crime in neighborhood, past 12 months	14.2 *	12.0	15.2	13.2	16.2
Homeless or lived in an emergency shelter, past 12 months	2.5	2.0	2.8	2.3	3.0
Had 3 or more material hardships[a]	28.1 *	26.6	27.1	26.9	31.7
Sample size	3,771	970	920	898	983

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[b] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[c] Total monthly income includes family income from all sources (earnings, welfare, food stamps, child support, and so on) but does not include income derived from the Earned Income Tax Credit (EITC). Therefore, income is underestimated for many of those working.

[d] Respondents indicated whether they had any of the following housing problems: broken windows, leaky ceilings, roaches/vermin, and problems with wiring, plumbing, heating, and appliances.

[e] Neighborhood problems are based on the interviewer's observations of five characteristics in the vicinity of the respondent's home: vacant lots, vandalism, abandoned buildings, teenage gangs, and litter or garbage in the streets.

III. Health Status and Behavior

Table C.3 presents data for various physical health outcomes across the four Urban Change sites (discussed in Chapter 4). As indicated in the table, in all four sites, the women's average scores on the physical component of the SF-12 (a standardized measure of physical health) were less favorable than the national norm for people age 18-44 (52.8). There were no significant site differences in mean scores on the SF-12 physical component or in the proportion of respondents scoring below 40 on the measure. However, there were significant differences in self-reported health status. Miami and Cleveland had the lowest proportions of women reporting that they were in fair or poor health (22.2 percent and 23.9 percent, respectively). In contrast, Los Angeles (27.6 percent) and Philadelphia (28.1 percent) had the highest proportions.[9] Philadelphia also had the highest percentage of women who reported that they had a physical problem that limited the amount or type of work they could do.

Across the four sites, about 9 percent of the women reported that they had collected disability income (Supplemental Security Income, or SSI) in the prior month. Women in Los Angeles were about half as likely as women in the other three sites to be collecting SSI (about 5 percent versus about 10 percent). This is consistent with the fact that Los Angelenos were least likely to say they had a physical disability that limited their work.

The majority of respondents in all four sites were overweight. The site differences on this health outcome were relatively modest but significant, ranging from a low of 65.2 percent in Cleveland to a high of 70.2 percent in Los Angeles. Site differences in smoking, however, were substantial. About twice as many women in Cleveland (50.8 percent) as in Miami (26.8 percent) smoked cigarettes. Similarly, more than twice as many women from Cleveland (17.3 percent) as from Miami (8.0 percent) had the combined risk factors of being obese and being a smoker. It should be noted that, for all four Urban Change sites, the rate of smoking in the Urban Change sample was nearly double the 1997 smoking prevalence rates in their respective states.[10]

Overall, then, there is no clear-cut pattern to the site differences on the health indicators available in the Urban Change survey. Women in Miami had the most favorable outcomes in terms of smoking and self-reported health status. Nevertheless, their average score on the physical component of the SF-12 was similar to the average scores of women in the other sites.

IV. Mental Health

Table C.4 presents site differences for key mental health indicators that were discussed in Chapter 5. Women in the four sites had similar average scores on the mental component of the

---

[9] However, site differences in self-rated health disappeared when other background characteristics of the women were controlled, as shown in Appendix Table E.2.

[10] The prevalence rates for adult smoking in 1997 were: California, 19.2 percent; Florida, 22.0 percent; Ohio, 26.1 percent; and Pennsylvania, 23.8 percent (National Center for Health Statistics, 1999). Thus, both in the Urban Change sample and in the general adult population, smoking rates were higher in Ohio and Pennsylvania than in the other two sites/states. In the Urban Change sample, the site differences in smoking remained significant even when other background variables were controlled (see Appendix Table E.2).

The Project on Devolution and Urban Change

Appendix Table C.3

Selected Health Status and Health Behavior Outcomes, by Site

Outcome	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Physical component of SF-12[a]					
Mean score	46.9	46.8	47.5	47.1	46.4
Scored less than 40 (%)	31.2	30.2	29.3	31.1	34.2
Reports fair to poor health (%)	25.5 **	23.9	27.6	22.2	28.1
Has a physical problem that limits work or type of work (%)	24.0 **	24.8	20.6	23.1	27.2
Received disability income (SSI), prior month (%)	8.7 **	10.1	5.5	9.2	9.8
Moderately to severely overweight[b] (%)	66.1 *	65.2	70.2	65.7	63.4
Currently smokes cigarettes (%)	39.8 ***	50.8	31.5	26.8	48.4
Currently smokes cigarettes and is obese (%)	13.3 ***	17.3	11.9	8.0	15.5
Sample size	3,771	970	920	898	983

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[b] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

The Project on Devolution and Urban Change

Appendix Table C.4

Selected Mental Health Outcomes, by Site

Outcome	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Mental component of SF-12[a]					
Mean score	47.1	46.9	47.5	47.5	46.5
Scored less than 40 (%)	32.7	32.5	30.3	32.4	35.4
Mean CES-D score (%)					
Risk of depression[b]	17.6 *	17.1	17.0	18.0	18.2
None	50.1	50.0	52.5	49.6	48.6
Moderate	22.6	24.7	22.5	21.7	21.5
High	27.2 *	25.3	25.0	28.7	29.9
Self-reported substance use, prior month (%)					
Drunk 3 or more times	7.0 ***	8.3	5.0	5.0	9.1
Any drug use	9.6 ***	11.4	6.9	4.7	14.9
Heroin, cocaine, or crack	2.5 ***	1.8	1.3	2.0	4.6
Physically abused, past 12 months[c] (%)	8.8 *	9.6	6.5	8.0	10.7
Sample size	3,627	938	874	867	948

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[b] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

[c] The respondent reported that she was hit, slapped, or kicked.

SF-12, and in all cases the mean scores were less favorable than the mean for people age 18-44 in the standardization sample (49.8). There were also no site differences in the percentage of women scoring below 40 on the mental component of the SF-12. However, there were modestly significant site differences on the CES-D scale; in all four sites, the scores indicated a fairly high level of depression. The average CES-D scores ranged from a low of 17.0 (least depressed) in Los Angeles to a high of 18.2 (most depressed) in Philadelphia. About 30 percent of the women in Philadelphia, compared with 25 percent in Cleveland, were at high risk of depression.[11]

Site differences in substance use were more substantial. For all three indicators shown in Table C.4, women in Philadelphia had the highest rates of substance abuse. They were nearly twice as likely as women in Los Angeles and Miami to report having gotten drunk at least three times in the prior month (9.1 percent versus 5.0 percent, respectively). And they were nearly three times as likely as women in Miami to have used any drug (14.9 percent versus 4.7 percent).[12] Women in Cleveland were more like those in Philadelphia in terms of drug and alcohol use than like the women in the other two sites.

The pattern is similar in terms of domestic violence. Women in Philadelphia were most likely to report having been physically abused (10.7 percent), followed by women in Cleveland (9.6 percent). Physical abuse was least prevalent in Los Angeles (6.5 percent).[13]

In summary, data from the Urban Change survey suggest that women in Philadelphia had the least favorable outcomes in terms of indicators of emotional well-being;[14] women in Los Angeles and Miami fared better. In all four sites, however, emotional distress was high.

V. Health Insurance and Health Care Access and Utilization

Table C.5 presents information about how the sites differed with regard to selected health insurance and health care access outcomes that were discussed in Chapter 6. As seen in the table, site differences with respect to individual and family insurance status were sizable and statistically significant. Miami respondents were the most likely to say that they had been uninsured in the month prior to the survey: The percentage uninsured in the month prior to the survey was more than twice as high in Miami (30.1 percent) as in Philadelphia, the site with the lowest percentage uninsured (13.1 percent). The percentage of families in which everyone was uninsured in the prior month was also nearly twice as high in Miami (15.9 percent) as in Philadelphia (8.1 percent). Similarly, women in Miami had the highest rate of having had a spell without insurance in the prior year and of having any personal health-related expenses in the prior year.[15] It should

---

[11] The site differences in being at risk of depression were not significant once background characteristics were controlled, as indicated in Appendix Table E.3.

[12] Site differences in drug use in the prior month remained highly significant when the women's background characteristics were controlled. See Appendix Table E.3.

[13] Women in Philadelphia were most likely to have been physically abused, even when their background characteristics were statistically controlled, as shown in Appendix Table E.3.

[14] The high rate of emotional distress among Philadelphia respondents is consistent with the fact that, using city-wide data, the suicide rate is higher in Philadelphia than in the other three sites (see Table 2.3).

[15] Site differences with respect to uninsurance remained statistically significant even after other background characteristics were controlled (see Appendix Table E.4).

The Project on Devolution and Urban Change

Appendix Table C.5

Selected Health Insurance and Health Care Expenditure Outcomes, by Site

Outcome (%)	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Uninsured, prior month					
Everyone in family[a]	10.3 ***	10.4	10.3	16.1	8.4
Self	16.0 ***	20.5	16.0	29.6	12.7
Past 12 months:					
Ever uninsured	24.8 ***	35.8	24.8	39.7	21.9
Any health-related expenditure	43.7 ***	41.4	43.7	45.1	30.1
Had more than 1 emergency room visit	38.1 ***	50.1	38.1	36.0	43.6
Had an unmet need for medical or dental care	28.6 ***	28.8	28.6	40.4	22.0
Had no usual source of care	13.3 ***	8.5	13.3	16.4	7.0
Felt access to health care was harder than past 12 months	32.6 ***	33.4	37.3	31.9	28.1
Sample size	3,770	970	920	897	983

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Family includes the respondent's husband or partner, her children, and any other household member she considers as immediate family and with whom she shares resources. Each person's health insurance status was determined, and these data were used to construct these outcomes.

be noted that the results for the Urban Change sample are not consistent with state patterns in rates of uninsurance based on national data. In 1998, California ranked as the third-highest state for its uninsurance rate (U.S. Bureau of the Census, 1999b), and yet Urban Change women from Los Angeles were less likely to be uninsured than women from Miami or Cleveland. The discrepancy is likely to reflect the fact that Los Angeles had the highest rate of welfare receipt (and therefore Medicaid coverage) of the four sites in this study.

Consistent with the site differences relating to health insurance, women in Miami were most likely to say that they had no usual source of care; they were more than twice as likely to say this as women in Philadelphia (16.4 percent versus 7.0 percent, respectively). However, somewhat paradoxically, residents of Miami were also least likely to have used emergency rooms in the prior year. Women from Cleveland were particularly likely to have had an emergency room visit (50.1 percent).

Compared with women living in the other three cities, women living in Miami were particularly likely to report an unmet need for medical care or dental care. Two out of five Miami residents (40.4 percent) — compared with less than 30 percent of the women in the other three cities — said that they or someone in their family had needed medical or dental care in the prior year but could not afford to get it. Again, this is likely to be a function of the fact that women in Miami were least likely to have health insurance.

In summary, health care coverage and access varied substantially across the four sites. Women in Miami were especially likely to be uninsured and to have problems accessing health care. This is consistent with the fact that Miami had the highest proportion of welfare leavers; as discussed in Chapter 6, welfare exit was strongly related to loss of insurance and to problems accessing health care. It also reflects, to a lesser extent, the fact that an appreciable minority of Miami sample members were noncitizens, who in general had less favorable access to health care than citizens, after they had left welfare.[16] However, of all four sites, Miami had the highest percentage of women who lacked insurance in the prior month among *both* citizens and noncitizens.

VI. Children's Health and Health Care

Table C.6 presents selected children's health outcomes discussed in Chapter 7, by site. The sites differed significantly with regard to many of the variables examined, but there was no clear-cut pattern. For example, Miami was the site with the lowest rate of children with accidents or injuries in the prior year (15.3 percent, compared with 22.6 percent in Philadelphia), but it was also the site with the highest rate of children's hospitalizations (15.9 percent, compared with 10.5 percent in Los Angeles). However, women in the four sites were comparable in terms of having a child with an illness or disability and in terms of having a preschooler or adolescent in fair or poor health.

---

[16] Among all former welfare recipients in the sample, 60.2 percent of the noncitizens lacked health insurance in the month before the interview, compared with 34.4 percent of U.S. citizens. This is consistent with a recent analysis that has documented the effects of citizenship on rates of health insurance among immigrants living in the United States (Carrasquillo, Carrasquillo, and Shea, 2000).

The Project on Devolution and Urban Change

Appendix Table C.6

Selected Children's Health Outcomes, by Site

Outcome (%)	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Any child:					
With an illness/disability that limits mother's work or school participation	19.8	20.3	18.8	18.3	21.5
Had an accident or injury requiring medical attention, past 12 months	18.5 ***	19.3	16.4	15.3	22.6
Hospitalized, past 12 months	14.1 **	15.2	10.5	15.9	14.7
Without health insurance, prior month	16.5 ***	15.1	17.6	21.1	12.8
Health insurance, prior month					
No health insurance	15.6 **	14.8	16.2	20.7	11.0
Covered by Medicaid	66.7 ***	54.5	70.6	69.6	71.8
Covered by CHIP	5.2 ***	11.2	3.7	2.8	3.3
Not seen a doctor for routine care, prior 12 months	15.9 ***	14.1	23.0	14.3	12.2
Not seen a dentist, prior 12 months	30.5 ***	37.0	36.1	22.0	27.0
Sample size	3,741	960	913	891	977

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

Consistent with the fact that Miami had the highest percentage of welfare leavers, women in Miami were most likely to have an uninsured child (21.1 percent); those in Philadelphia were least likely (12.8 percent). CHIP coverage was most common in Cleveland: 11.0 percent of adolescent focal children and 9.6 percent of younger focal children (not shown) were reported to have CHIP coverage.[17] In addition to being the site with the fewest uninsured children, Philadelphia had the lowest rate of forgone routine medical care in the previous year for adolescent (12.2 percent) and preschool focal children (3.6 percent, not shown). However, it was Miami rather than Philadelphia that had the best record for forgone dental care: 22.0 percent of the older focal children in Miami had not seen a dentist in the prior year, compared with 37.0 percent of the adolescents in Cleveland.[18]

VII. Multiple Health and Nonhealth Barriers

Chapter 8 presented two cumulative indexes of problems or barriers that could constrain women's ability to get or keep a job. The first was a multiple health barrier index that indicates the number of health problems, out of eight considered, that each woman faced. The second was a nonhealth barrier index that summed the number of structural and human capital barriers (out of five indicators) confronting the women.

The health constraints of the women in all four sites were similar, as shown in Table C.7. There were no significant differences in the average number of health barriers, nor in the percentages of people with many or no health barriers. Sites did differ, however, in terms of the structural and human capital barriers, such as educational attainment. Women in Cleveland had the lowest number of such barriers and were also most likely to have none of these barriers. By contrast, women in Los Angeles had the most structural barriers.

On average, women in the Urban Change sample had 2.7 combined health and nonhealth barriers to employment, ranging from a low of 2.5 in Cleveland to a high of 2.9 in Los Angeles. Women in Cleveland were especially unlikely to have five or more employment barriers. However, it is apparent that substantial proportions of women in all four sites faced impediments to finding or sustaining employment.

VIII. Work/Welfare Group Differences in Health Outcomes, by Site

Table C.8 shows work/welfare group differences for five key health outcomes, for all four sites. These analyses were undertaken to determine whether the work/welfare group differences described in this report were primarily driven by large group differences in just one or two sites. As this table indicates, the *differences among the four research groups were largely comparable across all four sites.* With few exceptions, women in every site who worked had better health outcomes than women who did not — especially if they had left welfare; and welfare leavers in

---

[17] Note, however, that the Children's Health Insurance Program was just beginning to be implemented when the survey data were collected.

[18] It is striking, however, that women in Miami were more likely than women in other sites to report that someone in their family had had an unmet dental need in the prior year (36.1 percent versus 24.1 percent in Cleveland). This could mean that the disparity between children's and parents' dental care was greater in Miami than elsewhere.

The Project on Devolution and Urban Change

Appendix Table C.7

Health[a] and Nonhealth Barriers,[b] by Site

Outcome	Full Sample	Cuyahoga County	Los Angeles County	Miami-Dade County	Philadelphia County
Health barriers[a]					
Mean number	1.5	1.4	1.4	1.4	1.6
None (%)	25.8	26.0	25.3	28.7	23.4
3 or more (%)	19.4	19.1	17.5	19.9	21.1
Nonhealth barriers[b]					
Mean number	1.3 ***	1.1	1.5	1.3	1.2
None (%)	27.4 ***	32.4	22.9	24.0	29.8
Health barriers and nonhealth barriers					
Mean number	2.7 ***	2.5	2.9	2.7	2.7
None (%)	8.6 *	10.1	6.4	8.0	10.0
Sample size	3,595	917	873	864	941

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. The sample sizes for individual outcomes may fall short of the reported sample sizes because of missing or unusable items from some interviews.

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI greater than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

[b] Nonhealth barriers include: no high school diploma or GED, no paid work experience, unable to converse in English, has three children or more, and has a child under age 3.

The Project on Devolution and Urban Change

Appendix Table C.8

Selected Health Outcomes, by Site and Mother's Work and Welfare Status[a]

Outcome (%)	Full Sample	Working, Not on Welfare	Working, on Welfare	Not Working, on Welfare	Not Working, Not on Welfare
Food insecure[b]					
Cuyahoga County	45.1 *	40.5	52.1	44.4	55.8
Los Angeles County	56.3 ***	44.4	55.6	61.5	61.8
Miami-Dade County	53.8 *	48.4	52.1	58.6	58.2
Philadelphia County	41.0 **	34.6	34.6	46.3	46.7
Reports fair to poor health					
Cuyahoga County	23.9 ***	17.9	19.6	28.0	39.6
Los Angeles County	27.6 *	25.8	21.0	32.3	27.1
Miami-Dade County	22.2 ***	12.6	13.3	32.1	32.4
Philadelphia County	28.1 ***	15.9	24.3	35.5	40.0
High risk for depression[c]					
Cuyahoga County	25.3	20.9	28.6	26.8	31.8
Los Angeles County	25.0 **	18.6	19.5	31.2	26.5
Miami-Dade County	28.7 ***	20.6	17.4	38.7	36.3
Philadelphia County	29.9 ***	18.9	30.4	35.1	40.8
3 or more health barriers[d]					
Cuyahoga County	19.1 ***	12.2	13.6	27.4	25.0
Los Angeles County	17.5 ***	8.5	11.3	25.1	20.0
Miami-Dade County	19.9 ***	8.1	19.8	35.2	17.2
Philadelphia County	21.1 ***	8.7	12.3	31.6	28.2
Uninsured, prior month					
Cuyahoga County	20.5 ***	33.2	8.3	4.9	47.8
Los Angeles County	16.0 ***	28.5	3.6	8.9	57.3
Miami-Dade County	29.6 ***	49.0	7.7	7.0	46.3
Philadelphia County	12.7 ***	21.0	6.5	4.0	30.3

(continued)

Appendix Table C.8 (continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: Calculations for this table used data for all sample members in the 1998-1999 Urban Change Respondent Survey who were or had previously been welfare recipients. Sample sizes may vary because of missing values. The maximum sample size for each site follows: Cuyahoga County = 961, Los Angeles County = 914, Miami-Dade County = 890, and Philadelphia County = 978.

Only one difference remained significant with controls--Child A not seen doctor, BUT, not seen dentist BECAME significant with controls. Child B not seen doctor narrowly missed (.06).

Rounding may cause slight discrepancies in sums and differences.

The numbers shown are not statistically adjusted. An analysis of variance and chi-squared tests was applied to test the significance of group differences. Statistical significance levels are indicated as * (.05), ** (.01), or *** (.001).

[a] Women in the Urban Change sample were categorized into one of the four groups based on their self-reported work and welfare status at the time of the interview.

[b] Respondents were placed in one of the four food security categories based on their scores on the 18-item Household Food Security Scale.

[c] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

[d] Health barriers include: score of less than 40 on the SF-12 physical component, at moderate or high risk of depression, had more than five doctor visits in the past 12 months, morbidly obese (BMI less than 40), homeless or sheltered in prior year, physically abused in past 12 months, used a hard drug in prior month, and has one child or more with an illness or disability affecting the respondent's ability to work.

all four sites were most likely to be uninsured in the prior month. In all four sites the group with the worst health scenario was women who neither worked nor received welfare, because they tended to have among the poorest health outcomes and were also most likely to have health care access problems.

IX. Summary

Women in the four sites differed substantially in terms of their background characteristics. They also differed in terms of their material hardships and several of their health status outcomes. The pattern of site differences, however, was much less consistent and clear-cut than the pattern with respect to the women's work/welfare status, as discussed in this report. Some sites were especially disadvantaged on some outcomes but were better off than other sites on other outcomes.

Only two themes emerged from the analysis of site differences. First, the women in Philadelphia appeared to be most at risk in terms of their mental health outcomes. They were most likely to be at high risk of depression, to have used alcohol in the prior month, to have used hard drugs in the prior month, and to have been physically abused in the year prior to the interview. Most of these differences persisted even when their background characteristics — including their employment and welfare status — were controlled. There is no obvious explanation for this pattern of findings.

Second, women in Miami were more likely than women in other sites to experience safety net problems in relation to health insurance. Across most health care access outcomes, women in Miami had the most acute difficulties. This likely reflects the facts that Florida has seen the steepest decline in welfare caseloads of any of the four states involved in this study and that welfare leavers as a group had substantial health care vulnerabilities — whether or not they had left welfare for work. Also, Florida has one of the lowest limits of the four sites on adult eligibility for Medicaid (see Table 2.1, Chapter 2). It should be noted, however, that all sites have taken steps since the 1998-1999 Urban Change interviews to address welfare leavers' problems with Medicaid coverage.

Appendix D

Ever-Receivers and Never-Receivers of Welfare in the Urban Change Sample

In this report, the analysis of survey data excluded the 4.8 percent of the sample (188 women) who had never received welfare.[1] The decision to exclude these women was based on several considerations. First, the exclusion of these women would result in analyses that would be sharper, because the groups of women in the work/welfare categories would be more homogeneous. Second, some of the analyses focus on the relationship between income transitions and health outcomes; thus, using only ever-receivers of welfare ensured that the women in the two nonrecipient groups were necessarily welfare *leavers*. Third, the group of never-receivers was sufficiently small that its exclusion would have little effect on the results. Moreover, because of the small number of never-receivers, their experiences may not adequately represent women who had received food stamps but not welfare.

Nevertheless, some analyses were undertaken to better understand who these women were and whether their exclusion changed the report findings in any important way. Table D.1 summarizes selected background characteristics both of the women who were or had been welfare recipients (that is, the sample used in the analyses reported in the text) and of women who had never been recipients. The two groups were similar in several respects. There were no significant differences in terms of such characteristics as educational attainment, number of children, and number of household members. However, the never-receivers were significantly older and were less likely to have a preschool-age child. Furthermore, women who had never received welfare were substantially more likely to be Hispanic, to be noncitizens, and to be married. The two groups were equally likely to be employed at the time of the interview, but women who never received welfare were significantly more likely to work full time. The two groups reported similar average family income from all sources in the prior month.

Table D.2 compares the two groups with respect to selected health and health-related outcomes. The two groups were more similar with respect to health and health care than they were with regard to their demographic characteristics. Women who had never been on welfare had fewer housing hardships than women who had been welfare recipients, but overall the groups were fairly comparable in terms of material hardships. The two groups were also similar in terms of several indicators of health and mental health, *except* that women who had never received welfare were significantly less likely to smoke or to use drugs. However, there were noteworthy differences with regard to health care and health insurance. The never-receivers were significantly *less* likely than the ever-receivers to have health insurance, and they were also more likely to say that they had needed to see a dentist but could not do so because of financial constraints. Having a regular source of health care was similar in the two groups.[2]

---

[1] These women had, however, received food stamp benefits. The sample was drawn from administrative records and included women who, in May 1995, were single mothers receiving either food stamps or cash welfare.

[2] On the insurance and health care access outcomes, women who never received welfare did not differ significantly from women who had *left* welfare.

The Project on Devolution and Urban Change

Appendix Table D.1

Selected Background Characteristics of Ever-Receivers and Never-Receivers of Cash Welfare Benefits in the Urban Change Respondent Survey Sample

Characteristic	Full Sample	Ever Received Cash Welfare Benefits	Never Received Cash Welfare Benefits
Average age	33.7 ***	33.6	35.9
African-American (%)	67.6 ***	68.4	52.9
Hispanic (%)	25.3 ***	24.5	42.2
White, not Hispanic (%)	5.3	5.4	3.2
Not a U.S. citizen (%)	10.2 ***	9.7	19.1
Married, living with spouse (%)	9.4 ***	8.8	20.9
Living with partner, unmarried (%)	9.9	10.1	5.9
Average household size	4.2	4.2	4.0
Average number of children in household	2.4	2.4	2.3
Has no children in household (%)	4.3 *	4.1	8.0
Average age of youngest child	6.8 *	6.8	7.7
Child under age 6 in household (%)	46.8 *	47.1	39.6
Does not have a GED or diploma (%)	54.3	54.2	56.5
Has some college credit (%)	18.2	18.1	20.4
Currently employed (%)	49.8	49.6	54.8
Currently employed full time (%)	36.2 **	35.8	45.7
Never employed (%)	8.3 *	8.0	13.3
Currently receiving welfare (%)	52.9 ***	55.6	0.0
Family received welfare during childhood (%)	45.0 ***	45.8	28.7
Average household income, past month[a] ($)	1,277.99	1,276.28	1,321.40
Sample size	3,956	3,768	188

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE:

[a] Total monthly income includes family income from all sources (earnings, welfare, food stamps, child support, and so on) but does not include income derived from the Earned Income Tax Credit (EITC). Therefore, income is underestimated for many of those working.

The Project on Devolution and Urban Change

Appendix Table D.2

Selected Health-Related Outcomes of Ever-Receivers and Never-Receivers of Cash Welfare Benefits in the Urban Change Respondent Survey Sample

Outcome (%)	Full Sample	Ever Received Cash Welfare Benefits	Never Received Cash Welfare Benefits
Food insecure[a]	51.1	48.8	50.5
Has 2 or more housing problems[b]	25.4 **	25.8	16.6
Has 2 or more neighborhood problems[c]	48.9 *	49.4	39.9
Lived in emergency shelter or was homeless, past 12 months	2.4	2.5	0.5
Had 3 or more material hardships[d]	28.0	28.2	22.7
In fair or poor health	25.6	25.5	28.4
Currently smokes cigarettes	39.1 ***	39.8	25.5
Overweight/obese[e]	66.0	66.1	64.3
At moderate/high risk of depression[f]	49.6	49.7	47.0
Was drunk 3 times or more, past 30 days	6.8	7.0	3.9
Used drugs, past 30 days	9.3 ***	9.7	1.7
Was physically abused, past 12 months[g]	8.7	8.7	8.5
Had unmet medical need, past 12 months	23.7	25.9	28.9
Had unmet dental need, past 12 months	25.7 ***	25.0	38.7
Has regular source of health care	88.9	88.9	89.3
Ever not insured, past 12 months	26.4 ***	25.9	36.6
Family currently has no insurance	11.4 **	10.9	20.9
Sample size	3,956	3,768	188

(continued)

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[b] Respondents indicated whether they had any of the following housing problems: broken windows, leaky ceilings, roaches/vermin, and problems with wiring, plumbing, heating, and appliances.

[c] Neighborhood problems are based on the interviewer's observations of five characteristics in the vicinity of the respondent's home: vacant lots, vandalism, abandoned buildings, teenage gangs, and litter or garbage in the streets.

Appendix Table D.2 (continued)

[d] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

[e] The ranges for weight were calculated utilizing the body mass index (BMI), which references the risk of morbidity and mortality associated with weight. A person whose BMI is 30 or higher is classified as obese.

[f] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

[g] The respondent reported that she was hit, slapped, or kicked.

It should be noted that when the women who had never received welfare were included in the analyses of health outcomes, the findings regarding differences among the four work/welfare groups did not change for any of the outcomes shown in Table D.2. Moreover, when "ever-receipt" of welfare was added as a covariate in the model (together with other background characteristics such as age, race/ethnicity, and education), the covariate was statistically significant for only one outcome: current smoking status. Thus, in this population of low-income urban women who had been public assistance recipients in 1995, ever receiving welfare appeared to be only marginally related to health outcomes once other factors were controlled.

Appendix E

Regression Tables for Selected Health Outcomes

The Project on Devolution and Urban Change

Appendix Table E.1

Estimated Regression Coefficients for Material Hardship Outcomes

	Food Insecurity[a]			Worst-Case Housing Needs[b]			3+ Material Hardships[c]		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Constant	0.71	0.13	0.00 *	0.34	0.13	0.01 **	0.57	0.12	0.00 ***
Site									
Cuyahoga County	0.06	0.02	0.01 **	0.02	0.02	0.32	-0.05	0.02	0.03 *
Los Angeles County	0.12	0.02	0.00 ***	0.01	0.12	0.80	-0.03	0.02	0.15
Miami-Dade County	0.12	0.02	0.00 ***	-0.05	0.02	0.02 *	-0.03	0.02	0.17
Race/ethnicity									
Black	-0.05	0.06	0.47	0.02	0.06	0.70	0.05	0.06	0.41
Hispanic	0.05	0.06	0.46	0.12	0.06	0.06	0.00	0.06	1.00
White	-0.03	0.07	0.66	0.16	0.07	0.02 *	0.06	0.07	0.33
Is a U.S. citizen	-0.05	0.03	0.10	-0.05	0.03	0.11	-0.01	0.03	0.82
Age	0.01	0.00	0.00 ***	0.00	0.00	0.45	0.00	0.00	0.07
Education									
Less than high school/GED	0.02	0.02	0.36	0.03	0.02	0.09	0.05	0.02	0.00 **
More than high school/GED	-0.03	0.02	0.26	0.02	0.02	0.35	0.06	0.02	0.77
Number of children in household	0.03	0.01	0.00	0.00	0.01	0.76	0.02	0.01	0.00 ***
Child under age 6 in household	-0.03	0.09	0.10	0.00	0.02	0.96	-0.04	0.02	0.02
Living with a partner/husband	-0.07	0.02	0.00	-0.10	0.02	0.00 ***	-0.05	0.02	0.02 *
Age	0.01	0.00	0.00	0.00	0.01	0.45	0.00	0.00	0.07
Months elapsed between May 1995 and interview date	-0.01	0.00	0.00	0.00	0.00	0.79	-0.01	0.00	0.00 ***

(continued)

Appendix Table E.1 (continued)

Variable	Food Insecurity[a]			Worst-Case Housing Needs[b]			3+ Material Hardships[c]		
	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Work/welfare status									
Working, not on welfare	-0.11	0.03	0.00	-0.17	0.00	0.00 ***	-0.01	0.03	0.00 ***
Working, on welfare	-0.07	0.03	0.02	-0.08	0.01	0.01 **	-0.60	0.03	0.04 *
Not working, on welfare	0.05	0.03	0.08	0.08	0.00	0.00 **	0.02	0.03	0.40
Mean of dependent variable	0.50								
R-square	0.06								
F-statistic	12.55								
p-value of F-statistic	0.00								
Sample size			48.8			34.1			28.1

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] This measure collapses the three insecure categories from the Household Food Security Scale (insecure, no hunger; insecure, moderate hunger; insecure, severe hunger).

[b] Families have worst-case housing needs if they have no rental assistance and pay more than 50 percent of their income (not including food stamps) for rent and utilities.

[c] The eight material hardships used in this index include: food insecurity, receipt of emergency food in prior month, spends more than 50 percent of income (including food stamps) on housing, has two or more housing problems, had utilities turned off in past 12 months, has two or more neighborhood problems, witnessed a violent crime in the neighborhood, and homeless or sheltered in past 12 months.

The Project on Devolution and Urban Change

Appendix Table E.2

Estimated Regression Coefficients for Physical Health Outcomes

	Score Less Than 40 on SF-12[a]			In Fair to Poor Health			Currently Smokes		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Constant	-0.037	0.115	0.747	-0.040	0.061	0.507	0.308	0.122	0.011 *
Site									
Cuyahoga County	-0.001	0.020	0.970	0.004	0.010	0.727	0.014	0.021	0.585
Los Angeles County	-0.029	0.021	0.165	-0.010	0.011	0.384	-0.118	0.022	0.000 ***
Miami-Dade County	-0.005	0.020	0.815	0.010	0.011	0.368	-0.165	0.021	0.000 ***
Race/ethnicity									
Black	-0.032	0.057	0.578	-0.052	0.029	0.079	0.051	0.058	0.387
Hispanic	0.029	0.058	0.612	-0.014	0.030	0.652	-0.064	0.060	0.280
White	-0.043	0.064	0.501	-0.049	0.033	0.144	0.266	0.066	0.000 ***
Is a U.S. citizen	-0.081	0.028	0.004 **	0.006	0.014	0.657	0.112	0.029	0.000 ***
Education									
Less than high school/GED	0.029	0.016	0.067	0.029	0.008	0.001 ***	0.114	0.017	0.000 ***
More than high school/GED	0.002	0.020	0.906	0.019	0.010	0.006 **	-0.022	0.021	0.301
Number of children in household	0.020	0.005	0.000 ***	-0.007	0.003	0.013	-0.019	0.006	0.001 ***
Child under age 6 in household	0.002	0.017	0.915	-0.016	0.009	0.071	-0.033	0.018	0.066
Living with a partner/husband	-0.016	0.018	0.386	-0.007	0.010	0.494	-0.008	0.019	0.672
Months elapsed between May 1995 and interview date	-0.002	0.002	0.393	0.000	0.001	0.993	-0.008	0.002	0.000 ***

(continued)

Appendix Table E.2 (continued)

	Score Less Than 40 on SF-12[a]			In Fair to Poor Health			Currently Smokes		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Work/welfare status									
Working, not on welfare	-0.129	0.023	0.000 ***	-0.060	0.012	0.000 ***	-0.079	0.024	0.001 ***
Working, on welfare	-0.097	0.027	0.000 ***	-0.050	0.014	0.000 ***	-0.004	0.028	0.894
Not working, on welfare	-0.033	0.023	0.161	0.014	0.012	0.243	0.028	0.024	0.244
Sample size			23.9			25.5			39.8

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

Appendix Table E.3

Estimated Regression Coefficients for Mental Health Outcomes

	CES-D More Than 16[a]			Used Drugs, Past Month			Physically Abused, Past 12 Months		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Constant	0.759	0.134	0.000 ***	0.246	0.078	0.002 **	0.059	0.077	0.443
Site									
Cuyahoga County	0.008	0.023	0.707	-0.036	0.013	0.007 **	-0.014	0.013	0.293
Los Angeles County	-0.270	0.024	0.261	-0.058	0.014	0.000 ***	-0.038	0.014	0.006 **
Miami-Dade County	0.014	0.023	0.560	-0.084	0.014	0.000 ***	-0.020	0.013	0.140
Race/ethnicity									
Black	-0.066	0.066	0.315	0.029	0.038	0.440	0.011	0.037	0.769
Hispanic	-0.051	0.067	0.448	-0.044	0.039	0.262	0.007	0.038	0.845
White	0.012	0.074	0.869	0.000	0.043	0.991	0.036	0.042	0.395
Is a U.S. citizen	0.059	0.032	0.078	0.016	0.019	0.395	0.042	0.018	0.023 *
Age	0.003	0.001	0.012 *	0.000	0.001	0.488	0.000	0.001	0.974
Education									
Less than high school/GED	0.084	0.018	0.000 ***	0.009	0.011	0.401	0.010	0.011	0.320
More than high school/GED	-0.081	0.023	0.000 ***	-0.027	0.013	0.045 *	-0.010	0.013	0.458
Number of children in household	-0.016	0.006	0.046 *	-0.010	0.004	0.008 **	0.002	0.004	0.657
Child under age 6 in household	-0.031	0.019	0.113	-0.023	0.011	0.046 *	0.005	0.011	0.650
Living with a partner/husband	-0.038	0.021	0.073	0.011	0.016	0.345	-0.005	0.012	0.667
Months elapsed between May 1995 and interview date	-0.008	0.002	0.001 ***	-0.002	0.001	0.179	0.000	0.001	0.742

(continued)

Appendix Table E.3 (continued)

Variable	CES-D More Than 16[a]			Used Drugs, Past Month			Physically Abused, Past 12 Months		
	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Work/welfare status									
Working, not on welfare	-0.126	0.027	0.000 ***	-0.038	0.016	0.015 *	-0.049	0.015	0.001 ***
Working, on welfare	-0.055	0.031	0.079	0.005	0.018	0.785	-0.038	0.018	0.035 *
Not working, on welfare	0.016	0.027	0.556	0.009	0.016	0.579	-0.014	0.015	0.368
Sample size			49.6			9.2			8.8

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTE:

[a] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

The Project on Devolution and Urban Change

Appendix Table E.4

Estimated Regression Coefficients for Health Insurance Outcomes

	Ever Insured, Past Year			Uninsured, Past Month		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Constant	0.319	0.118	0.007 **	0.371	0.080	0.000 ***
Site						
Cuyahoga County	0.096	0.020	0.000 ***	0.018	0.014	0.190
Los Angeles County	0.018	0.021	0.576	0.024	0.014	0.089
Miami-Dade County	0.065	0.020	0.002 **	0.048	0.014	0.001 ***
Race/ethnicity						
Black	-0.043	0.056	0.447	-0.080	0.038	0.038 *
Hispanic	-0.039	0.057	0.500	-0.053	0.039	0.179
White	0.059	0.064	0.351	-0.043	0.043	0.323
Is a U.S. citizen	-0.062	0.029	0.032 *	-0.050	0.019	0.010 **
Age	0.000	0.001	0.542	0.001	0.001	0.129
Education						
Less than high school/GED	0.020	0.016	0.229	0.012	0.011	0.268
More than high school/GED	-0.010	0.020	0.616	-0.004	0.014	0.005 **
Number of children in household	-0.023	0.006	0.000 ***	-0.019	0.004	0.000 ***
Child under age 6 in household	-0.051	0.017	0.003 **	-0.032	0.012	0.006 **
Living with a partner/husband	0.002	0.019	0.900	0.021	0.013	0.097
Months elapsed between May 1995 and interview date	0.007	0.002	0.001 ***	0.000	0.001	0.768
Work/welfare status						
Working, not on welfare	-0.089	0.025	0.000 ***	-0.045	0.017	0.007 **
Working, on welfare	-0.289	0.024	0.000 ***	-0.219	0.019	0.000 ***
Not working, on welfare	-0.268	0.024	0.000 ***	-0.213	0.017	0.000 ***
Sample size			30.4			423.0

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

The Project on Devolution and Urban Change

Appendix Table E.5

Estimated Regression Coefficients for Health Care Access/Utilization Outcomes

	Has a Usual Source of Care			Access Harder Than Before			Unmet Medical Care Need		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Constant	0.858	0.082	0.000 ***	0.189	0.124	0.128	0.293	0.109	0.007 **
Site									
Cuyahoga County	-0.014	0.014	0.310	0.061	0.021	0.004 **	0.057	0.019	0.002 **
Los Angeles County	-0.057	0.082	0.000 ***	0.021	0.022	0.329	0.103	0.019	0.000 ***
Miami-Dade County	-0.032	0.015	0.031 *	0.079	0.022	0.000 ***	0.076	0.020	0.000 ***
Race/ethnicity									
Black	0.050	0.040	0.203	-0.044	0.059	0.462	-0.110	0.052	0.036 *
Hispanic	0.013	0.040	0.756	0.030	0.028	0.624	-0.086	0.053	0.110
White	-0.011	0.045	0.807	0.031	0.067	0.643	-0.045	0.059	0.444
Is a U.S. citizen	0.106	0.019	0.000 ***	-0.013	0.030	0.660	-0.023	0.026	0.365 ***
Age	0.000	0.001	0.686	0.003	0.001	0.050 *			
Education									
Less than high school/GED	0.004	0.011	0.721	0.014	0.017	0.400	0.037	0.015	0.014 *
More than high school/GED	0.038	0.014	0.007 **	-0.021	0.022	0.336	0.032	0.019	0.090 **
Number of children in household	0.003	0.004	0.459	-0.006	0.006	0.291	-0.014	0.005	0.006 **
Child under age 6 in household	0.026	0.012	0.031 *	-0.022	0.018	0.221	-0.022	0.016	0.162
Living with a partner/husband	0.001	0.013	0.910	-0.036	0.020	0.067	0.078	0.017	0.000 ***
Months elapsed between May 1995 and interview date	-0.004	0.001	0.005 **	0.003	0.002	0.114	0.000	0.002	0.877

(continued)

Appendix Table E.5 (continued)

Variable	Has a Usual Source of Care Parameter Estimate	Has a Usual Source of Care Standard Error	Has a Usual Source of Care p-Value	Access Harder Than Before Parameter Estimate	Access Harder Than Before Standard Error	Access Harder Than Before p-Value	Unmet Medical Care Need Parameter Estimate	Unmet Medical Care Need Standard Error	Unmet Medical Care Need p-Value
Work/welfare status									
Working, not on welfare	0.012	0.016	0.478 **	-0.002	0.025	0.940	-0.033	0.022	0.125
Working, on welfare	0.059	0.019	0.002 **	-0.091	0.029	0.002 **	-0.195	0.025	0.000 ***
Not working, on welfare	0.075	0.016	0.000 ***	-0.101	0.025	0.000 ***	-0.181	0.022	0.000 ***
Sample size			88.8			32.6			29.7

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

The Project on Devolution and Urban Change

Appendix Table E.6

Estimated Regression Coefficients for Children's Health Care Access/Utilization Outcomes

	Any Child with Disability Limiting Work			Any Uninsured Child, Prior Month		
Variable	Parameter Estimate	Standard Error	p-Value	Parameter Estimate	Standard Error	p-Value
Constant	-0.094	0.107	0.377	0.402	0.097	0.000 ***
Site						
Cuyahoga County	0.005	0.018	0.776	0.018	0.016	0.265
Los Angeles County	-0.019	0.019	0.326	0.059	0.017	0.001 ***
Miami-Dade County	-0.005	0.019	0.796	0.043	0.017	0.010 **
Race/ethnicity						
Black	0.027	0.051	0.604	-0.041	0.047	0.375
Hispanic	0.070	0.052	0.179	-0.008	0.047	0.864
White	0.065	0.058	0.265	0.016	0.053	0.769
Is a U.S. citizen	0.136	0.025	0.000 ***	-0.097	0.023	0.000 ***
Age	0.000	0.001	0.703	0.005	0.001	0.000 ***
Education						
Less than high school/GED	0.009	0.015	0.558	0.003	0.013	0.819
More than high school/GED	-0.005	0.018	0.794	-0.039	0.017	0.021 **
Number of children in household	0.027	0.005	0.000 ***	-0.006	0.005	0.244
Child under age 6 in household	-0.007	0.015	0.669	-0.028	0.014	0.044 **
Living with a partner/husband	0.007	0.017	0.661	0.024	0.015	0.113
Months elapsed between May 1995 and interview date	0.002	0.002	0.323 **	-0.003	0.002	0.050 *

(continued)

Appendix Table E.6 (continued)

Variable	Any Child with Disability Limiting Work Parameter Estimate	Standard Error	p-Value	Any Uninsured Child, Prior Month Parameter Estimate	Standard Error	p-Value
Work/welfare status						
Working, not on welfare	-0.082	0.022	0.000 **	-0.045	0.020	0.024
Working, on welfare	-0.033	0.025	0.190 **	-0.026	0.023	0.000 ***
Not working, on welfare	0.026	0.022	0.229 ***	-0.259	0.020	0.000 ***
Sample size			19.8			16.5

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

Appendix F

Item Frequencies for Three Health-Related Scales

The Project on Devolution and Urban Change

Appendix Table F.1

Household Food Security Scale, Item Frequencies

In the Past 12 Months...	Sample Affirming (%)
Stage 1 Questions	
1. Worried that our food would run out before we got money to buy more.	65.3
2. Food that we bought just didn't last and we didn't have money to get more.	56.2
3. Couldn't afford to eat balanced meals.	34.8
4. Relied on only a few kinds of low-cost food to feed my children because I was running out of money to buy food.[a]	47.9
5. Couldn't feed my children a balanced meal, because I couldn't afford that.[a]	29.7
Stage 2 Questions	
6. My children weren't eating enough because I just couldn't afford enough food.[a]	17.5
7. Adult in household cut the size of meals or skipped meals because there wasn't enough money for food.	21.4
8. Adult cut or skipped meals for 3 or more months.	16.7
9. Ate less than I felt I should because there wasn't enough money for food.	25.2
10. Hungry but didn't eat because I couldn't afford enough food.	14.1
11. Lost weight because I didn't have enough money for food.	8.5
Stage 3 Questions	
12. Adult in household did not eat for a whole day because there wasn't enough money for food.	8.7
13. Adult did not eat for a whole day during 3 or more months.	6.6
14. Cut the size of children's meals because there wasn't enough money for food.[a]	8.2
15. Children skipped meals because there wasn't enough money for food.[a]	5.0
16. Children skipped meals during three or more months.[a]	4.0
17. Children were hungry, but I just couldn't afford more food.[a]	5.6
18. Children ever not eaten for a whole day because there wasn't enough money for food.[a]	1.6

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES: The Household Food Security Scale is administered in three stages; respondents affirming (indicating agreement with) any of the first five questions are asked questions in stage 2, and those affirming any stage 2 questions are asked questions in stage 3. The percentages shown are for the entire sample of Urban Change survey respondents who completed the stage 1 questions.

[a] Households without children are not asked items 4, 5, 6, 14, 15, 16, 17, or 18.

The Project on Devolution and Urban Change

Appendix Table F.2

Individual Item Responses for SF-12[a]

Question	Percentage
In general, how would you say your health is?	
Excellent	18.1
Very good	24.2
Good	30.2
Fair	19.4
Poor	5.4
How often does your health limit moderate activities?[b]	
Limited a lot	17.3
Limited a little	18.9
Not limited at all	60.8
How often does your health limit climbing flights of stairs?	
Limited a lot	19.5
Limited a little	23.2
Not limited at all	54.0
During the past month have you:	
Accomplished less than you would have liked as a result of your physical health?	
Yes	34.4
No	61.9
Been limited in the kind of work or other activities?	
Yes	27.3
No	68.5
Accomplished less than you would have liked as a result of any emotional problems?	
Yes	32.8
No	63.5
Not done work or other activities as carefully as usual?	
Yes	25.2
No	70.7
During the past month, how much did pain interfere with your normal work?	
Not at all	47.9
A little bit	24.7
Moderately	9.0
Quite a bit	10.2
Extremely	4.7

(continued)

Appendix Table F.2 (continued)

Question	Percentage
During the past month, how often have you felt calm and peaceful?	
None of the time	8.3
A little of the time	16.7
Some of the time	27.2
Most of the time	31.1
All of the time	13.4
During the past month, how often have you felt energetic?	
None of the time	8.6
A little of the time	15.6
Some of the time	29.8
Most of the time	28.2
All of the time	14.5
During the past month, how often have you felt downhearted and blue?	
None of the time	28.3
A little of the time	28.2
Some of the time	25.6
Most of the time	9.7
All of the time	5.1
During the past month, how often have your physical health or emotional problems interfered with your social activities?	
None of the time	50.5
A little of the time	17.8
Some of the time	17.0
Most of the time	7.5
All of the time	4.0

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] The Short Form 12 Health Survey (SF-12) is a 12-item scale providing a generic, multidimensional measure of physical or mental health status. It is standardized utilizing a sample of the general U.S. population to a mean of 50 and a standard deviation of 10. Different versions of the instrument inadvertently omitted response options for two questions. To account for this oversight, responses to the remaining options for these two questions were weighted.

[b] For example, moving a table.

321

The Project on Devolution and Urban Change

Appendix Table F.3

Individual Item Responses for CES-D[a]

	Frequency			
Item	Less Than One Day[b]	One to Two Days[c]	Three to Four Days[d]	Five to Seven Days[e]
During the past week:				
I was bothered by things that don't usually bother me	42.7	32.4	14.3	8.8
My appetite was poor	46.3	27.4	16.8	7.8
I could not shake off blues even with help from family	50	22.9	14.9	10.4
I felt just as good as other people	16	12.8	15.6	53.7
I had trouble keeping my mind on what I was doing	47	28.2	13.6	8.9
I felt depressed	39.4	28.9	15.7	13.5
I felt everything I did was an effort	27.2	21.6	20.7	27.3
I felt hopeful about the future	17.3	15.6	21.4	42.7
I thought my life was a failure	58.6	18.5	10.8	8.1
I felt fearful	59.1	19	11	7.1
My sleep was restless	39.3	26.3	17.1	14.4
I was happy	11.7	16.7	27.8	41.2
I talked less than usual	43.2	27.4	17.8	8.8
I felt lonely	45.6	23.7	14.6	13.5
I felt people were unfriendly	56.3	23.3	11	6.3
I enjoyed life	11.8	12.4	19.7	52.8
I had crying spells	58.8	17.7	11.5	9.1
I felt sad	44.4	28.4	14	10.5
I felt that people disliked me	66.4	16.5	8.2	6.3
I could not get going	51.2	26.5	12.3	7.4

SOURCE: MDRC calculations from the Urban Change Respondent Survey.

NOTES:

[a] Risk of depression was assessed utilizing standard criteria for the Center for Epidemiological Studies-Depression (CES-D) scale. CES-D scores range from 0 to 60. A score less than 16 is categorized as at low risk, a score of 16 to 23 is categorized as at moderate risk, and a score greater than 23 is classified as at high risk of depression.

[b] Rarely or none of the time.

[c] Some or a little of the time.

[d] Occasionally or a moderate amount of the time.

[e] Most or all of the time.

References

Aday, L. A., and Andersen, R. M. (1974). A framework for the study of access to medical care. *Health Services Research, 9,* 208-220.

Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., and Syme, S. L. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist, 49,* 15-24.

Alaimo, K., Briefel, R. R., Frongillo, E. A., and Olson, C. M. (1998). Food insufficiency exists in the United States: Results from the third National Health and Nutrition Examination Survey (NHANES III). *American Journal of Public Health, 88* (3), 419-426.

Allen, K., and Kirby, M. (2000). *Unfinished business: Why cities matter to welfare reform.* Washington, DC: Brookings Institution, Center on Urban and Metropolitan Policy.

Allison, K., Adlaf, E. M., Ialomiteanu, A., and Rehm, J. (1999). Predictors of health risk among young adults. *Canadian Journal of Public Health, 90,* 85-89.

Allison, D. B., Zannolli, R., and Narayan, K. (1999). The direct health care costs of obesity in the United States. *American Journal of Public Health, 89,* 1194-1199.

Anda, R. F., Croft, J. B., Felitti, V. J., Nordenberg, D., Giles, W. H., and Williamson, D. (1999). Adverse childhood experiences and smoking during adolescence and adulthood. *Journal of the American Medical Association, 282,* 1652-1658.

Andersen, R. M. (1968). Behavioral model of families' use of health services. Research Series No. 25. Chicago: University of Chicago, Center for Health Administration Studies.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36,* 1-10.

Andersen, R. M., and Aday, L. A. (1978). Access to medical care in the U.S.: Realized and potential. *Medical Care, 16* (7), 533-546.

Anderson, C. L., Agran, P. F., Winn, D. G., and Tran, C. (1998). Demographic risk factors for injury among Hispanic and non-Hispanic white children. *Injury Prevention, 4,* 33-38.

Anderson, S. A., Ed. (1990). Core indicators of nutritional status for difficult-to-sample populations. *Journal of Nutrition, 120,* 1559-1600.

Aneshensel, C. S. (1985). The natural history of depressive symptoms. *Research in Community and Mental Health, 5,* 45-75.

Aneshensel, C. S. (1992). Social stress: Theory and research. *Annual Review of Sociology, 18,* 15-38.

Baker, D., and North, K. (1999). Does employment improve the health of lone mothers? *Social Science and Medicine, 49,* 121-131.

Baker, D., Taylor, H., and Henderson, J. (1998). Inequality in infant morbidity. *Journal of Epidemiology and Community Health, 52,* 451-458.

Barusch, A., Taylor, M., and Derr, M. (1999). *Understanding families with multiple barriers to self-sufficiency.* Salt Lake City: University of Utah.

Bassuk, E. L., Buckner, J. C., Weinreb, L. F., Browne, A., Bassuk, S. S., Dawson, R., and Perloff, J. N. (1997). Homelessness in female-headed families: Childhood and adult risk and protective factors. *American Journal of Public Health, 87*, 241-248.

Bassuk, E., Weinreb, L .F., Buckner, J. C., Browne, A., Saolomon, S., and Bassuk, S. S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *Journal of the American Medical Association, 276*, 640-646.

Bates, A. S., and Wolinsky, F. D. (1998). Personal, financial, and structural barriers to immunization in socioeconomically disadvantaged urban children. *Pediatrics, 101*, 591-596.

Bender, R., Trautner, C., Spraul, M., and Berger, M. (1998). Assessment of excess mortality in obesity. *American Journal of Epidemiology, 147*, 42-48.

Bickel, G., Carlson, S., and Nord, M. (1999). *Household food security in the United States, 1995-1998.* Washington, DC: U.S. Department of Agriculture, Food and Nutrition Service.

Bird, C. E., and Fremont, A. M. (1991). Gender, time use, and health. *Journal of Health and Social Behavior, 32,* 14-129.

Blank, R. M. (1987). The effect of medical need on AFDC and Medicaid participation. Discussion Paper 831-87. Madison: University of Wisconsin, Institute for Research on Poverty.

Blazer, D. G., Kessler, R. C., McGonagle, K. A., and Swartz, M. S. (1994). The prevalence and distribution of major depression in a national community sample: The National Comorbidity Survey. *American Journal of Psychiatry, 151* (7), 979-986.

Bloom, B., Simpson, G., Cohen, R. A., and Parson, P. E. (1997). Access to health care. Part 2: Working-age adults. *Vital and Health Statistics*, Series 10, No. 197. Washington, DC: U.S. Department of Health and Human Services, National Center for Health Statistics.

Boone, A., Erickson, G., and Arch-Walton, M. (1999). Voices of the women survivors of domestic violence and welfare. Pages 95-106 in *Battered women, children and welfare reform: Ties that bind,* ed. Ruth Brandwein. Thousand Oaks, CA: Sage Publications.

Boyer, D. (1999). Childhood sexual abuse: The forgotten issue in adolescent pregnancy and welfare reform. Pages 131-143 in *Battered women, children and welfare reform: Ties that bind,* ed. Ruth Brandwein. Thousand Oaks, CA: Sage Publications.

Brandwein, R., Ed. (1999). *Battered women, children and welfare reform: Ties that bind.* Thousand Oaks, CA: Sage Publications.

Bray, G. A. (1996). Health hazards of obesity. *Endocrinology and Metabolism Clinics of North America, 25* (4), 907-919.

Breslau, N., Peterson, E. L., Schultz, L. R., Chilcoat, H. D., and Andreski, P. (1998). Major depression and stages of smoking. *Archives of General Psychiatry, 2* (55), 161-166.

Browne, A., Salomon, A., and Bassuk, S. (1999). The impact of recent partner violence on poor women's capacity to maintain work. *Violence Against Women, 5* (4), 393-426.

Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., and Iwen, B. (1999). *Homelessness: Programs and the people they serve.* Washington, DC: Urban Institute.

Calle, E. E., Thun, M. J., Petrelli, J. M., Rodriguez, C., Heath, C. W., Jr. (1999). Body-mass index and mortality in a prospective cohort of U.S. adults. *New England Journal of Medicine, 341* (15), 1097-1105.

Campbell, J. A. (1999). Health insurance coverage 1998. *Current Population Reports: Consumer Income*, P60-208. Washington, DC: U.S. Bureau of the Census.

Cancian, M., Haveman, R., Meyer, D. R., and Wolfe, B. (2000). *Before and after TANF: The economic well-being of women leaving welfare.* Special Report No. 77. Madison: University of Wisconsin, Institute for Research on Poverty.

Carlson, S. J., Andrews, M. S., and Bickel, G. W. (1999). Measuring food insecurity and hunger in the United States: Development of a national benchmark measure and prevalence estimates. *Journal of Nutrition, 129*, 510S-516S.

Carrasquillo, O., Carrasquillo, A. I., and Shea, S. (2000). Health insurance coverage of immigrants living in the United States: Differences by citizenship status and country of origin. *American Journal of Public Health, 90*, 917-923.

Carrasquillo, O., Himmelstein, D. U., Woolhandler, S., and Bor, D. H. (1999). Trends in health insurance coverage, 1989-1997. *International Journal of Health Services Research, 29* (3), 467-483.

Center for Studying Health System Change (1998). *Estimates of health insurance coverage in the Community Tracking Study and the Current Population Survey.* Technical Publication 16, November. Washington, DC: Center for Studying Health System Change.

Center on Urban and Metropolitan Policy (1999). *The state of welfare caseloads in America's cities: 1999.* Washington, DC: Brookings Institution.

Centers for Disease Control (1995). Health insurance coverage and receipt of preventive health services: United States, 1993. *Morbidity and Mortality Weekly Report, 44*, 219-225.

Centers for Disease Control, tobacco Web site: http://www.cdc.gov/tobacco

Chavkin, W., Romero, D., and Wise, P. H. (2000). State welfare reform policies and declines in health insurance. *American Journal of Public Health, 90*, 900-908.

Child Trends (1999). *A century of children's health and well-being.* Washington, DC: Child Trends.

Cohen, B., Ohls, J., Andrews, M., Ponza, M., Moreno, L., Zambrowski, A., and Cohen, R. (1999). *Food Stamp participants' food security and nutrient availability.* Princeton, NJ: Mathematica Policy Research, Inc.

Cohen, D., Spear, S., Scribner, R., Kissinger, P., Mason, K., and Widgen, J. (2000). "Broken windows" and gonorrhea. *American Journal of Public Health, 90*, 230-236.

Colby, J. P., Linsky, A. S., and Straus, M. A. (1994). Social stress and state-to-state differences in smoking and smoking related mortality in the United States. *Social Science and Medicine, 38*, 373-381.

Colten, M. E., Cosenza, C., and Allard, M. A. (1996). *Domestic violence among Massachusetts AFDC recipients.* Boston: University of Massachusetts, McCormack Institute.

Comstock, G. W., and Helsing, K. J. (1976). Symptoms of depression in two communities. *Psychological Medicine, 6*, 551-564.

Coulton, C., Pasqualone, C., Bania, N., Martin, T., Lalich, N., Fernando, M., and Li, F. (2000). *How are they managing? A six-month retrospective of Cuyahoga County families leaving welfare.* Cleveland: Case Western Reserve University, Center on Urban Poverty and Social Change.

Cumella, S., Grattan, E., and Vostanis, P. (1998). The mental health of children in homeless families and their contact with health, education, and social services. *Health and Social Care in the Community, 6*, 331-342.

Cunningham, P. J., Grossman, J. M., St. Peter, R. F., and Lesser, C. S. (1999). Managed care and physicians' provision of charity care. *Journal of the American Medical Association, 281*, 24-31.

Cutts, D. B., Pheley, A. M., and Geppert, J. S. (1998). Hunger in Midwestern inner-city children. *Archives of Pediatric and Adolescent Medicine, 152* (5), 489-493.

Danziger, S., Corcoran, M., Danziger, S., and Heflin, C. (1999). Post-TANF work and well-being: Early findings from the second wave of the Women's Employment Study. Paper presented at the Northwestern/University of Chicago Joint Center for Poverty Research Conference, "For Better or for Worse: State Welfare Reform and the Well-Being of Low-Income Families and Children." Washington, DC, Georgetown University, September 16-17.

Danziger, S., Corcoran, M., Danziger, S., Heflin, C., Kalil, A., Levine, J., Rosen, D., Seefeldt, K., Siefert, K., and Tolman, R. (2000). *Barriers to the employment of welfare recipients.* Madison: University of Wisconsin, Institute for Research on Poverty.

Davidson, G., and Moscovice, I. (1989). Health insurance and welfare reentry. *Health Services Research, 24* (5), 599-614.

Davis, J.; and Kutter, C. J. (1998). Independent living skills and posttraumatic stress disorder in women who are homeless. *American Journal of Occupational Therapy, 52*, 39-44.

Delva, J., and Kameoka, V. A. (1999). Risk for alcohol and drug abuse among ethnically diverse female recipients of public assistance. *Ethnicity and Disease, 9* (2), 237-245.

Detre, K. M., Feinleib, M., Matthews, K. A., and Kerr, B. W. (1987). The federal women's study. In *Coronary heart disease in women*, ed. E. D. Eaker, B. Packard, N. Wenger, T. Clarkson, and H. Typroler. New York: Haymarket Doyma.

Docs4Kids Project (1998). *Not safe at home: How America's housing crisis threatens the health of its children.* Boston: Boston Medical Center.

Dohrenwend, B. S., and Dohrenwend, D. P., Eds. (1981). *Stressful life events and their contexts.* New York: Prodist.

Duchon, L. M., Weitzman, B. C., and Shinn, M. (1999). The relationship of residential instability to medical care utilization among poor mothers in New York City. *Medical Care, 37*, 1282-1293.

Durazo-Arvizu, R. A., McGee, D. L., Cooper, R. S., Liao, Y., and Luke, A. (1998). Mortality and optimal body mass in a sample of the U.S. population. *American Journal of Epidemiology, 147*, 739-749.

Edin, K., and Lein, L. (1997). *Making ends meet.* New York: Russell Sage Foundation.

Edin, K., Scott, E. K., London, A. S., and Mazelis, J. M. (1999). My children come first. Paper presented at the Northwestern/University of Chicago Joint Center for Poverty Research Conference, "For Better or for Worse: State Welfare Reform and the Well-Being of Low-Income Families and Children," Washington, DC, Georgetown University, September 16-17.

Eggleston, P. A., Wood, R. A., Rand, C., Nixon, W. J., Chen, P. H., and Lukk, P. (1999). Removal of cockroach allergen from inner-city homes. *Journal of Allergy and Clinical Immunology, 104*, 842-846.

Eisenstat, S. A., and Bancroft, L. (1999). Domestic violence. *New England Journal of Medicine, 341*, 886-892.

Elender, F., Bentham, G., and Langford, I. (1998). Tuberculosis mortality in England and Wales during 1982-1992. *Social Science and Medicine, 46*, 673-681.

Elliott, G. R., and Eisdorfer, C., Eds. (1982). *Stress and human health.* New York: Springer.

Ellwood, M. (1999). The Medicaid eligibility maze: Coverage expands, but enrollment problems persist. *Assessing the New Federalism: Issues and Options for States,* Occasional Paper No. 30. Washington, DC: Urban Institute.

Ellwood, M., and Ku, L. (1998). Welfare and immigration reforms: Unintended side effects for Medicaid. *Health Affairs, 17* (3), 137-151.

Ellwood, M., and Lewis, K. (1999). On and off Medicaid: Enrollment patterns for California and Florida in 1995. *Assessing the New Federalism: Issues and Options for States,* Occasional Paper No. 27. Washington, DC: Urban Institute.

Essen, J., Fogelman, K., and Head, J. (1978). Children's housing and their health and physical development. *Child Care, Health, and Development, 4*, 357-369.

Evans, G. W., Lepore, S. J., Shejwal, B. R., and Palsane, M. N. (1998). Chronic residential crowding and children's well-being: An ecological perspective. *Child Development, 69*, 14-23.

Evans, R. G, Barer, M. L., and Marmor, T. R., Eds. (1994). *Why are some people healthy and others not?* New York: Aldine de Gruyter.

Fall, C. H., Goggin, P. M., Hawtin, P., Fine, D., and Duggleby, S. (1997). Growth in infancy, infant feeding, childhood living conditions, and Helicobacter pylori infection at age 70. *Archives of the Diseases of Childhood, 77*, 310-331.

Families USA Foundation (1999). *Losing health insurance: The unintended consequences of welfare reform.* Washington, DC: Families USA Foundation.

Families USA Foundation (2000). *Go directly to work, do not collect health insurance: Low-income parents lose Medicaid.* Washington, DC: Families USA Foundation.

Farmer, P. (1997). Social scientists and the new tuberculosis. *Social Science and Medicine, 44*, 347-358.

Figlio, D. N., Gunderson, C., and Ziliak, J. P. (2000). The effects of the macroeconomy and welfare reform on food stamp caseloads. Paper presented at the Allied Social Science Association meeting, Boston, January 7-9.

Flores, G., Bauchner, H., Feinstein, A. R., and Nguyen, U. (1999). The impact of ethnicity, family income, and parental education on children's health and use of health services. *American Journal of Public Health, 89*, 1066-1071.

Fremont, A. M., and Bird, C. E. (1999). Integrating sociological and biological models. *Journal of Health and Social Behavior, 40*, 126-129.

French, M. T., Zarkin, G. A., Hartwell, T. D., and Bray, J. W. (1995). Prevalence and consequences of smoking, alcohol use, and illicit drug use in five worksites. *Public Health Reports, 110*, 593-599.

Frongillo, E. A. (1999). Validation of measures of food insecurity and hunger. *Journal of Nutrition, 129*, 506S-509S.

Fronstin, P. (1998). Sources of health insurance and characteristics of the uninsured. *EBRI Issue Brief* (204), 1-27.

Garrett, B., and Holahan, J. (1999). Health insurance coverage and health status of former welfare recipients. Working Paper. Washington, DC: Urban Institute.

Grant, B. F., and Dawson, D. A. (1996). Alcohol and drug use, abuse, and dependence among welfare recipients. *American Journal of Public Health, 86* (10), 1450-1454.

Greeno, C. G., and Wing, R. R. (1994). Stress-induced eating. *Psychological Bulletin, 115*, 444-464.

Grisso, J. A., Schwarz, D. F., Hirschinger, N., Sammel, M., Brensinger, C., Santanna, J., Lowe, R. A., Anderson, E., Shaw, L. M., Bethel, C. A., and Teeple, L. (1999). Violent injuries among women in an urban area. *New England Journal of Medicine, 341*, 1899-1905.

Grunberg, N. E., and Straub, R. O. (1992). The role of gender and taste class in the effects of stress on eating. *Health Psychologist, 11*, 97-100.

Gueron, J., and Pauly, E. (1991). *From welfare to work*. New York: Russell Sage Foundation.

Gunderson, C., LeBlanc, M., and Kuhn, B. (1999). The changing food assistance landscape: The Food Stamp Program in a post-welfare reform environment. Washington, DC: U.S. Department of Agriculture, Economic Research Service.

Guyer, J., and Mann, C. (1998). Taking the next steps: States can now take advantage of federal matching funds to expand health care coverage to low-income working parents. Washington, DC: Center for Budget and Policy Priorities.

Hamelin, A. M., Habicht, J. P., and Beaudry, M. (1999). Food insecurity: Consequences for the household and broader implications. *Journal of Nutrition, 129*, 525S-528S.

Hamilton, W. L., Cook, J. T., Thompson, W. W., Buron, L. F., Frongillo, E. A., Olson, C. M., and Wehler, C. A. (1997). *Household food security in the United States in 1995*. Washington, DC: U.S. Department of Agriculture.

Harris, K. M. (1996). Life after welfare: Women, work, and repeat dependency. *American Sociological Review, 61*, 407-426.

Harvey, P. A., Sacks, J. J., Ryan, G. W., and Bender, P. F. (1998). Residential smoke alarms and fire escape plans. *Public Health Reports, 113*, 459-464.

Health Care Finance Administration (2000). *The State Children's Health Insurance Program: Annual enrollment report, October 1, 1998 to September 30, 1999.* Washington, DC: HCFA.

Hershey, A. M., and Pavetti, L. (1997). Turning job finders into job keepers: The challenge of sustaining employment. In *The Future of Children* (Spring). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

Holl, J. L., Szilagyi, P. G., Rodewald, L. E., Byrd, R. S., and Weitzman, M. L. (1995). Profile of uninsured children in the United States. *Archives of Pediatric and Adolescent Medicine, 149*, 398-406.

Holzer, H. J. (1999). Will employers hire welfare recipients? *Focus, 20* (2), 26-30.

Humphreys, J. C., Lee, K. A., Neylan, T. C., and Marmar, C. R. (1999). Sleep patterns of sheltered battered women. *Image, 31*, 139-143.

James, W. P. (1998). What are the health risks? The medical consequences of obesity and its health risks. *Experimental and Clinical Endocrinology and Diabetes, 106* (Suppl. 2), 1-6.

Johnson, A., and Meckstroth, A. (1998). *Ancillary services to support welfare to work.* Princeton, NJ: Mathematica Policy Research, Inc.

Johnson, F. C., Hotchkiss, D. R., Mosck, N. B., McCandless, P., and Karolak, M. (1999). The impact of the AFDC and Food Stamp programs on child nutrition. *Journal of Health Care for the Poor and Underserved, 10*, 298-312.

Kandel, D. B., Davies, M., and Raveis, V. H. (1985). The stressfulness of daily social roles for women. *Journal of Health and Social Behavior, 26*, 64-78.

Kaplan, J. (1999). The use of sanctions under TANF. *Welfare Information Network Issue Notes, 3* (3).

Karasek, R. A., and Theorell, T. (1990). *Healthy work: Stress, productivity, and the reconstruction of working life.* New York: Basic Books.

Kendall, A., Olson, C. M., and Frongillo, E. A. (1995). Validation of the Radimer/Cornell measures of hunger and food insecurity. *Journal of Nutrition, 125*, 2793-2801.

Kendall, A., Olson, C. M., and Frongillo, E. A. (1996). Relationship of hunger and food insecurity to food availability and consumption. *Journal of the American Dietetic Association, 96*, 1010-1024.

Kennedy, B. P., Kawachi, I., Prothrow-Stith, D., Lochner, K., and Gupta, V. (1998). Social capital, income inequality, and firearm violent crime. *Social Science and Medicine, 47*, 7-17.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., and Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51* (1), 8-19.

Kiecolt-Glaser, J. K., and Glaser, R. (1995). Psychoneuroimmunology and health consequences: Data and shared mechanisms. *Psychosomatic Medicine, 57*, 268-274.

Knox, V., Miller, C., and Gennetian, L. (2000). *Reforming welfare and rewarding work: Final report on the Minnesota Family Investment Program*, Vol. 2: *Effects on children.* New York: MDRC.

Kozinet, C. A., Endom, E., Koerner, C., and Kovar, J. (1997). Blood lead screening among children seen in urban emergency centers. *Ambulatory Child Health, 3*, 241-247.

Ku, L., and Bruen, B. (1999). The continuing decline in Medicaid coverage. *Assessing the New Federalism: Issues and Options for States*, No. A-37. Washington, DC: Urban Institute.

Ku, L., and Garrett, B. (2000). How welfare reform and economic factors affected Medicaid participation: 1984-1996. *Assessing the New Federalism: Issues and Options for States*, Discussion Paper, February. Washington, DC: Urban Institute.

Kyriacou, D. N., Anglin, D., Taliaferro, E., Stone, S., Tubb, T., Linden, J. A., Muelleman, R., Barton, E., and Krau, J. F. (1999). Risk factors for injury to women from domestic violence against women. *New England Medical Journal, 341*, 1892-1898.

Lanphear, B. P., Weitzman, M., Winter, N. L., Eberly, S., Yakir, B., Tanner, M., Emond, M., and Matte, T. D. (1996). Lead-contaminated house dust and urban children's blood lead levels. *American Journal of Public Health, 86*, 1416-1421.

Lanzi, R. G., Pascoe, J. M., Keltner, B., and Ramey, S. L. (1999). Correlates of maternal depressive symptoms in a national Head Start program sample. *Archives of Pediatric and Adolescent Medicine, 153*, 801-807.

Larkin, H. (1999). Are more uninsured an unintended consequence of welfare reform? *Advances: The Robert Wood Johnson Foundation Quarterly Newsletter, 2*, 1-2.

Lee, I. M., Manson, J. E., Hennekens, C. H., and Paffenbarger, R. S. (1993). Body weight and mortality: A 27 year follow-up of middle-aged men. *Journal of the American Medical Association, 270*, 2823-2828.

Legal Action Center (1999). *Steps to success: Helping women with alcohol and drug problems move from welfare to work*. New York: Legal Action Center.

Lesser, C., and Cunningham, P. (1997). Access to care: Is it improving or declining? Data Bulletin No. 1, September. Washington, DC: Center for Studying Health System Change.

Link, B. G., and Phelan, J. C. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, Extra Issue, 80-94.

Link, B. G., and Phelan, J. C. (1996). Understanding sociodemographic differences in health: The role of fundamental social causes. *American Journal of Public Health, 86*, 471-473.

Linsky, A., and Straus, M. (1986). *Social stress in the United States: Links to regional patterns in crime and illness*. Dover, MA: Auburn House.

Lloyd, S. (1996). *The effects of violence on women's employment*. Chicago: Northwestern University, Institute for Policy Research.

Loprest, P. (1999). Families who left welfare: Who are they and how are they doing? *Assessing the New Federalism: Issues and Options for States*, Discussion Paper. Washington, DC: Urban Institute.

Loprest, P., and Acs, G. (1996). *Profile of disability among families on AFDC*. Washington, DC: Urban Institute.

Loprest, P. J., and Zedlewski, S. R. (1999). Current and former welfare recipients: How do they differ? *Assessing the New Federalism: Issues and Options for States*, Paper 99-17. Washington, DC: Urban Institute.

Lynch, J. W. (1996). Social position and health. *Annals of Epidemiology, 6*, 21-23.

Lynch, J. W., Kaplan, G. A., and Shema, S. J. (1997). Cumulative impact of sustained economic hardship on physical, cognitive, psychological, and social functioning. *New England Journal of Medicine, 337* (26), 1889-1895.

Macran, S., Clarke, L., and Joshi, H. (1996). Women's health: Dimensions and differentials. *Social Science and Medicine, 42*, 1203-1216.

Malmstrom, M., Sundquist, J., and Johansson, S. E. (1999). Neighborhood environment and self-reported health status: A multilevel analysis. *American Journal of Public Health, 89* (8), 1181-1186.

Marmot, M. G., Kogevinas, M., and Elston, M. A. (1998). Social/economic status and disease. *Annual Review of Public Health, 8*, 111-135.

Mayer, S. E., and Jencks, C. (1989). Poverty and the distribution of material hardship. *Journal of Human Resources, 29*, 88-113.

McAllister, L. E., and Boyle, J. S. (1998). Without money, means, or men: African American women receiving prenatal care in a housing project. *Family and Community Health, 21*, 67-79.

McCauley, J., Kern, D. E., Kolodner, K., Derogatis, L. R., and Bass, E. B. (1998). Relation of low-severity violence to women's health. *Journal of General Internal Medicine, 13*, 687-691.

McDowell, I., and Newell, C. (1996). *Measuring health: A guide to ratings scales and questionnaires*. New York: Oxford University Press.

McFarlane, J., Parker, B., Soeken, K., and Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. *Journal of the American Medical Association, 267*, 3176-3178.

McLeod, J. D., and Shanahan, M. J. (1996). Trajectories of poverty and children's mental health. *Journal of Health and Social Behavior, 37*, 207-220.

Menke, E. M., and Wagner, J. D. (1997). A comparative study of homeless, previously homeless, and never homeless school-aged children's health. *Issues in Comprehensive Pediatric Nursing, 20*, 153-173.

Meyer, B. D., and Rosenbaum, D. T. (1999). Welfare, the Earned Income Tax Credit, and the labor supply of single mothers. Working Paper No. W7363. Washington, DC: National Bureau of Economic Research.

Meyer, B. D., and Rosenbaum, D. T. (2000). Making single mothers work: Recent tax and welfare policy and its effects. Working Paper No. W7491. Washington, DC: National Bureau of Economic Research.

Meyer, M. H., and Pavalko, E. K. (1996). Family, work, and access to health insurance among mature women. *Journal of Health and Social Behavior, 37* (4), 311-325.

Meyers, M. K., Lukemeyer, A., and Smeeding, T. (1996). *Work, welfare, and the burden of disability: Caring for special needs children in poor families.* Income Security Policy Series, Paper No. 12. Syracuse, NY: Maxwell School of Citizenship and Public Affairs.

Miilunpalo, S., Vuori, I., Oja, P., Pasanen, M., and Urponen, H. (1997). Self-rated health status as a health measure: The predictive value of self-reported health status on the use of physician services and on mortality in the working-age population. *Journal of Clinical Epidemiology, 50* (5), 517-528.

Miller, J. E. (1998). Developmental screening scores among preschool-aged children: The roles of poverty and child health. *Journal of Urban Health, 75*, 135-152.

Miller, J. E. (2000). The effects of race/ethnicity and income on early childhood asthma prevalence and health care use. *American Journal of Public Health, 90*, 428-430.

Miller, T. R., Cohen, M. A., and Wierseman, B. (1995). *Crime in the United States: Victim costs and consequences.* Washington, DC: Urban Institute.

Millman, M., Ed. (1993). *Access to health care in America.* Washington, DC: National Academy Press.

Moffitt, R. A., and Slade, E. P. (1997). Health care coverage for children who are on and off welfare. *The Future of Children, 7* (1), 87-98.

Moffitt, R. A., and Wolfe, B. (1992). The effect of the Medicaid program on welfare participation and labor supply. *Review of Economics and Statistics, 74*, 615-626.

Montgomery, L. E., Kiely, J. L., and Pappas, G. (1996). The effects of poverty, race, and family structure on U.S. children's health. *American Journal of Public Health, 86,* 1401-1405.

Moore, T., and Selkowe, V. (1999). *Domestic violence victims in transition from welfare to work: Barriers to self-sufficiency and the W-2 response.* Milwaukee: Institute for Wisconsin's Future.

Morbidity and Mortality Weekly Report (1999). Neighborhood safety and the prevalence of physical inactivity. *Morbidity and Mortality Weekly Report, 48* (February 26), 143-146.

Moss, N. E., and Carver, K. (1998). The effect of WIC and Medicaid on infant mortality in the United States. *American Journal of Public Health, 88*, 1354-1362.

Mossey, J. M., and Shapiro, E. (1982). Self-rated health: A predictor of mortality among the elderly. *American Journal of Public Health, 72*, 800-808.

Mueller, L., and Ciervo, C. A. (1998). Smoking in women. *Journal of the American Osteopathic Association, 98* (Suppl. 12), S7-10.

Murphy, J. M., Wehler, C. A., Pagano, M. E., Little, M., Kleinman, R. E., and Jellinek, M. S. (1998). Relationship between hunger and psychosocial functioning in low-income American children. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 163-170.

Mutaner, C., Eaton, W. W., Diala, C., Kessler, R. C., and Sorlie, P. D. (1998). Social class, assets, organizational control and the prevalence of common groups of psychiatric disorders. *Social Science and Medicine, 47* (12), 2043-2053.

National Center for Health Statistics (1996). Health, United States, 1995. Hyattsville, MD: Public Health Service.

National Center for Health Statistics (1999). Current estimates from the National Health Interview Survey, 1996. *Health and Vital Statistics*, Series 10, No. 200. Washington, DC: U.S. Department of Health and Human Services, National Center for Health Statistics.

National Center for Health Statistics (2000). Healthy People 2000 review, 1998-1999. http://www.cdc.gov/nchs/data/hp2k99.pdf

National Center for Health Statistics Web site: http://www.cdc.gov/nchs/

National Heart, Lung, and Blood Institute Web site: http://www.nhlbi.nih.gov

Nelson, K., Brown, M. E., and Lurie, M. (1998). Hunger in an adult patient population. *Journal of the American Medical Association, 279* (15), 1211-1214.

Newacheck, P. W. (1994). Poverty and childhood chronic illness. *Archives of Pediatric Adolescent Medicine, 148*, 1143-1149.

Newacheck, P. W., Brindis, C. D., Cart, C. U., Marchi, K., and Irwin, C. E. (1999). Adolescent health insurance coverage: Recent changes and access to care. *Pediatrics, 104*, 195-202.

Newacheck, P. W., Hughes, D. C., and Stoddard, J. J. (1996). Children's access to primary care: Differences by race, income, and insurance status. *Pediatrics, 97*, 26-32.

Nies, M. A., Vollman, M., and Cook, T. (1999). African American women's experience with physical activity in their daily lives. *Public Health Nursing, 16*, 23-31.

Nightingale D. S., Trutko, J., and Barnow, B. S. (1999). *Status of the Welfare-to-Work Grants Program after one year.* Washington, DC: Urban Institute.

Nord, M., and Bickel, G. (1999). Estimating the prevalence of children's hunger from Current Population Survey Food Security Supplement. Paper presented at the Second Food Security Measurement and Research Conference, Alexandria, VA, February.

Nord, M., Jemison, K., and Bickel, G. (1999). Prevalence of food insecurity and hunger, by state, 1996-1998. Food Assistance and Nutrition Research Report No. 2. Washington, DC: U.S. Department of Agriculture.

O'Brien, E., and Feder, J. (1999). *Employment-based health insurance and its decline: The growing plight of low-wage workers.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

O'Campo, P., and Rojas-Smith, L. (1998). Welfare reform and women's health: Review of the literature and implications for state policy. *Journal of Public Health Policy, 19*, 420-445.

O'Campo, P., Xue, X., Wang, M., and Coughy, M. O. (1997). Neighborhood risk factors for low birthweight in Baltimore. *American Journal of Public Health, 87*, 1113-1118.

O'Hare, W. P., and Ritualo, A. R. (2000). Kids count: Identifying and helping America's most vulnerable. *Statistical Bulletin of the Metropolitan Insurance Company, 81*, 26-32.

Olson, C. M. (1999). Nutrition and health outcomes associated with food insecurity and hunger. *Journal of Nutrition, 129*, 521S-524S.

Olson, K., and Pavetti, L. (1996). *Personal and family challenges to the successful transition from welfare to work.* Washington, DC: Urban Institute.

Overpeck, M. D., and Kotch, J. B. (1995). The effect of U.S. children's access to care on medical attention for injuries. *American Journal of Public Health, 85*, 402-404.

Owen, A. L., and Owen, G. M. (1997). Twenty years of WIC: A review of some effects of the program. *Journal of the American Dietetic Association, 97*, 772-782.

Pamuk, E., Makuc, D., Heck, K., Reuben, C., and Lochner, K. (1998). Health, United States, 1998. *Socioeconomic status and health chartbook*. Hyattsville, MD: National Center for Health Statistics.

Pappas, G., Queen, S., Hadden, W., and Fisher, G. (1993). The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986. *New England Journal of Medicine, 329* (2), 103-109.

Pavetti, L. (1999). How much more can welfare mothers work? *Focus, 20* (2), 16-19.

Pear, R. (1999). More Americans were uninsured in 1998, U.S. says. *New York Times*, October 4, p. 1.

Pearlin, L. I. (1989). The sociological study of stress. *Journal of Health and Social Behavior, 30*, 241-256.

Perry, M., Kannel, S., Valdez, R. B., and Chang, C. (2000). *Medicaid and children: Overcoming barriers to enrollment*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Plichta, S. (1996). Violence and abuse: Implications for women's health. In *Women's health: The Commonwealth Fund Survey*, ed. M. Falid and K. Scott-Collins.

Polit, D. F., London, A., and Martinez, J. (2000). *Food security and hunger in poor mother-headed families in four U.S. cities*. New York: MDRC.

Pribesh, S., and Downey, D. B. (1999). Why are residential and school moves associated with poor school performance? *Demography, 36*, 521-534.

Quint, J. C., Bos, J. M., and Polit, D. F. (1997). *New Chance: Final report on a comprehensive program for young mothers in poverty and their children*. New York: MDRC.

Quint, J., Edin, K., Buck, M. L., Fink, B., Padilla, Y. C., Simmons-Hewitt, O., and Valmont, M. E. (1999). *Big cities and welfare reform: Early implementation and ethnographic findings from the Project on Devolution and Urban Change*. New York: MDRC.

Quint, J., Fink, B., and Rowser, S. (1991). *New Chance: Implementing a comprehensive program for disadvantaged young mothers and their children*. New York: MDRC.

Quint, J., and Widom, R. (2000). *Post-TANF food stamps and Medicaid benefits: Factors that aid or impede their receipt*. New York: MDRC.

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1* (3), 385-401.

Radloff, L. S., and Locke, B. Z. (1985). The Community Mental Health Assessment Survey and the CES-D Scale. In *Community Surveys of Psychiatric Disorder*, ed. M. M. Weissman, J. K. Menyers, and C. G. Ross. New Brunswick, NJ: Rutgers University Press.

Raphael, J. (1999). Keeping women poor: How domestic violence prevents women from leaving welfare and entering the world of work. Pages 31-43 in *Battered women, children and welfare reform: Ties that bind*, ed. Ruth Brandwein. Thousand Oaks, CA: Sage Publications.

Raphael, J., and Haennicke, S. (1999). *Keeping battered women safe through the welfare-to-work journey: How are we doing?* Ann Arbor: University of Michigan, Taylor Institute.

Raphael, J., and Tolman, R. M. (1997). *Trapped by poverty/Trapped by abuse.* Ann Arbor: University of Michigan, Research Development Center on Poverty, Risk, and Mental Health.

Reed, M. C. (2000). Why people change their health care providers. Data Bulletin No. 16, May. Washington, DC: Center for Studying Health System Change.

Reed, M. C., and St. Peter, R. F. (1997). Satisfaction and quality: Patient and physician perspectives. Data Bulletin No. 3. Washington, DC: Center for Studying Health System Change.

Reidy, M., with Mackey Bilaver, L., George, R. M., Lee, B. J., and Yeh, Y. (1998). The dynamics of AFDC, Medicaid, and Food Stamps: A preliminary report. Joint Center for Poverty Research Working Paper No. 4 (October).

Repetti, R. L., Matthews, K. A., and Waldron, I. (1989). Employment and women's health. *American Psychologist, 44,* 1394-1401.

Riccio, J., Freedman, S., and Harknett, K. (1995). *Can they all work? A study of the employment potential of welfare recipients in a welfare-to-work program.* New York: MDRC.

Rivara, F. P., and Barber, M. (1985). Demographic analysis of childhood pedestrian injuries. *Pediatrics, 76,* 375-381.

Roberts, E. M. (1997). Neighborhood social environments and the distribution of low birthweight in Chicago. *American Journal of Public Health, 87,* 597-603.

Roberts, G. L., Williams, G. M., Lawrence, J. M., and Raphael, B. (1998). How does domestic violence affect women's mental health? *Women and Health, 28,* 117-129.

Roberts, S. A. (1998). Community-level socioeconomic status effects on adult health. *Journal of Health and Social Behavior, 39,* 18-37.

Rodriguez, E., Allen J. A., Frongillo, E. A., Jr., and Chandra, P. (1999). Unemployment, depression, and health: A look at the African-American community. *Journal of Epidemiology and Community Health, 53* (6), 335-342.

Rose, D. (1999). Economic determinants and dietary consequences of food insecurity in the United States. *Journal of Nutrition, 129,* 517S-520S.

Rose, D., Habicht, J. P., and Devaney, B. (1998). Household participation in the Food Stamp and WIC programs increases the nutrient intakes of preschool children. *Journal of Nutrition, 128,* 548-555.

Rose, D., and Oliveira, V. (1997). Nutrient intakes of individuals from food-insufficient households in the United States. *American Journal of Public Health, 87,* 1956-1961.

Rosenstreich, D. L., Eggleston, P., Kattan, M., Baker, D., Slavin, R. G., Gergen, P., Mitchell, H., McNiff-Mortimer, K., Lynn, H., Ownby, D., and Malveaux, F. (1997). The role of cockroach allergy and exposure to cockroach allergen in causing morbidity among inner-city children with asthma. *New England Journal of Medicine, 336,* 1356-1363.

Ross, C. E., and Mirowsky, J. (1995). Does employment affect health? *Journal of Health and Social Behavior, 36,* 230-242.

Roxburgh, S. (1996). Gender differences in work and well-being: Effects of exposure and vulnerability. *Journal of Health and Social Behavior, 37*, 265-277.

Ryan, J., Zwerling, C., and Jones, M. (1996). Cigarette smoking at hire as a predictor of employment outcomes. *Journal of Occupational and Environmental Medicine, 38*, 928-933.

Sadowski, H., Ugarte, B., Kolvin, I., Kaplan, C., and Barnes, J. (1999). Early life family disadvantages and major depression in adulthood. *British Journal of Psychiatry, 174*, 112-120.

Salkever, D. S. (1982). Children's health problems and maternal work status. *Journal of Human Resources, 17*, 94-109.

Sard, B., and Daskal, J. (1998). *Housing and welfare reform: Some background information.* Washington, DC: Center on Budget and Policy Priorities.

Schmidt, L. Weisner, C., and Wiley, J. (1998). Substance abuse and the course of welfare dependency. *American Journal of Public Health, 88* (11), 1616-1622.

Schoen, C., Lyons, B., Rowland, D., Davis, K., and Puleo, E. (1997). Insurance matters for low-income adults: Results from a five-state survey. *Health Affairs, 16*, 163-171.

Scholes, D., McBride, C., Grothaus, L., Curry, S., Albright, J., and Ludman, E. (1999). The association between cigarette smoking and low-grade cervical abnormalities in reproductive-age women. *Cancer Causes and Control, 10* (5), 339-344.

Scott, E. K., Edin, K., London, A. S., and Mazelis, J. M. (forthcoming). My children come first: Welfare-reliant women's post-TANF views of work-family trade-offs and marriage. In *For better or for worse: Welfare reform and the well-being of children and families*, ed. Greg J. Duncan and P. Lindsay Chase-Lansdale. New York: Russell Sage Foundation.

Scott, R. I., and Wehler, C. A. (1998). Food insecurity/food insufficiency: An empirical examination of alternative measures of food problems in impoverished U.S. households. Madison: University of Wisconsin, Institute for Research on Poverty.

Seccombe, K., and Amey, C. (1995). Playing by the rules and losing: Health insurance and the working poor. *Journal of Health and Social Behavior, 36* (2), 168-181.

Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R., Jimenez, L., Duchon, L., James, S., and Krantz, D. H. (1998). Predictors of homelessness among families in New York City. *American Journal of Public Health, 88*, 1651-1657.

Shiono, P. H., Rauh, V. A., Park, M., Lederman, S. A., and Zuskar, D. (1997). Ethnic differences in birthweight: The role of lifestyle and other factors. *American Journal of Public Health, 87*, 787-793.

Simpson, G., Bloom, B., Cohen, R. A., and Parsons, P. E. (1997). Access to health care. Part 1: Children. *Vital and Health Statistics*, Series 10, 1-46. Washington, DC: U.S. Department of Health and Human Services, National Center for Health Statistics.

Smith, G. D., and Egger, M. (1992). Socioeconomic differences in mortality in Britain and the U.S. *American Journal of Public Health, 82*, 1079-1080.

Smith, V. K. (1999). Enrollment increases in state CHIP programs: December 1998 to June 1999. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Solomon, C. G., and Manson, J. E. (1997). Obesity and mortality: A review of the epidemiologic data. *American Journal of Clinical Nutrition, 66* (Suppl. 4), 1044S-1050S.

South, S. J., and Crowder, K. D. (1998). Avenues and barriers to residential mobility among single mothers. *Journal of Marriage and the Family, 60*, 866-877.

Speiglman, R., Fujiwara, L., Norris, J., and Green R. S. (1999). *Alameda County CalWORKs Needs Assessment: A look at potential health-related barriers to self-sufficiency*. Berkeley, CA: Public Health Institute.

Stark, E., and Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health*. Thousand Oaks, CA: Sage Publications.

Starkey, L. J., Gray-Donald, K., and Kuhnlein, H. V. (1999). Nutrient intake of food bank users is related to frequency of food bank use, household size, smoking, education and country of birth. *Journal of Nutrition, 129*, 883-889.

Stevens, J., Plankey, M. W., Williamson, D. F., Thun, M. J., Rust, P. F., and Palesch, Y. (1998). The body-mass index: Mortality relationship in white and African-American women. *Obesity Research, 6*, 268-277.

Stoddard, J. J., St. Peter, R. F., and Newacheck, P. W. (1994). Health insurance status and ambulatory care for children. *New England Journal of Medicine, 330*, 1421-1425.

Straus, M. A., and Gelles, R. J. (1990). *Physical violence in American families: Risk factors and adaptations to violence in 8145 families*. New Brunswick, NJ: Transaction Publishers.

Sugar, C. A., Sturm, R., Lee, T. T., Sherbourne, C. D., Olshen, R. A., Wells, K. B., and Lenert, L. A. (1998). Empirically defined health states for depression from the SF-12. *Health Services Research, 33* (4, Pt. 1), 911-928.

Surgeon Generals' Report on Mental Health (2000). http://www.surgeongeneral.gov/library/mentalhealth/home.html

Sweeney, E. (2000). *Recent studies indicate that many parents who are current or former welfare recipients have disabilities or other medical conditions*. Washington, DC: Center on Budget and Policy Priorities.

Tarasuk, V. S., and Beaton, G. H. (1999a). Household food insecurity and hunger among families using food banks. *Canadian Journal of Public Health, 90*, 109-113.

Tarasuk, V. S., and Beaton, G. H. (1999b). Women's dietary intakes in the context of household food insecurity. *Journal of Nutrition, 129*, 672-679.

Thoits, P. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior*, Extra Issue, 53-79.

Thompson, T. S., Holcomb, P. A., Loprest, P., and Brennan, K. (1998). *State welfare-to-work policies for people with disabilities: Changes since welfare reform*. Washington, DC: Urban Institute.

Tsai, S. P., Gilstrap, E. L., Colangelo, T. A., Menard, A. K., and Ross, C. E. (1997). Illness absence at an oil refinery and petrochemical plant. *Journal of Occupational and Environmental Medicine, 39*, 455-462.

Tucker, L. A., and Friedman, G. M. (1998). Obesity and absenteeism: An epidemiologic study of 10,825 employees. *American Journal of Health Promotion, 12*, 202-207.

Turner, R. J., Wheaton, B., and Lloyd, D. A. (1995). The epidemiology of social stress. *American Sociological Review, 60*, 104-124.

Twisk, J. W., Snel, J., Kemper, H. C., and van Mechelen, W. (1999). Changes in daily hassles and life events and the relationship with heart disease risk factors. *Journal of Psychosomatic Research, 46*, 229-240.

U.S. Bureau of the Census (1999). Internet Table 5: Uninsured children by age, race, and Hispanic origin, 1998. http//:www.census.gov/hhes/hlthins/hlthin98/hi98t5.html

U.S. Bureau of the Census (2000a). U.S. poverty tables. http://www.census.gov/hhes/poverty/histpov/perindex.html

U.S. Bureau of the Census (2000b). U.S. educational attainment tables. http://www.census.gov/population/www/socdemo.educ-atn.html

U.S. Department of Agriculture (1999). Who is leaving the Food Stamp Program? An analysis of caseload changes from 1994 to 1997. Washington, DC: USDA, Food and Nutrition Service.

U.S. Department of Health and Human Services (1998). Trends in the well-being of America's children and youth, 1998 edition. Washington, DC: DHHS.

U.S. Department of Health and Human Services (1999a). Change in TANF caseloads. Washington, DC: DHHS, Administration for Children and Families.

U.S. Department of Health and Human Services (1999b). Health, 1999. Washington, DC: DHHS.

U.S. Department of Health and Human Services (2000a). Healthy People 2010: Understanding and improving health. Washington, DC: DHHS.

U.S. Department of Health and Human Services (2000b). Mental health: A report of the Surgeon General. Washington, DC: DHHS.

U.S. Department of Health and Human Services (2000c). U.S. welfare caseloads information. http://www.acf.dhhs.gov/news/tables.htm

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (2000d). "Leavers" and diversion studies: Summary of research on welfare outcomes funded by ASPE. Washington, DC: DHHS.
http://aspe.hhs.gov/hsp/leavers99/ombsum.htm#medicaid

U.S. Department of Housing and Urban Development (1997). The impacts of federal welfare reform on HUD public and assisted housing: An initial assessment. Washington, DC: HUD.

U.S. Department of Housing and Urban Development (1998). A picture of subsidized households in 1998. Washington, DC: HUD.

U.S. Department of Housing and Urban Development (1999a). Waiting in vain: An update on America's rental housing crisis. Washington, DC: HUD.

U.S. Department of Housing and Urban Development (1999b). The widening gap: New findings on housing affordability in America. Washington, DC: HUD.

U.S. Department of Labor, Bureau of Labor Statistics (1999). Data from the 1998 Consumer Expenditure Survey: http://stats.bls.gov

U.S. General Accounting Office (1995). Health insurance for children: Many remain uninsured despite Medicaid expansion. Washington: GAO.

U.S. General Accounting Office (1999). Food Stamp Program: Various factors have led to declining participation. Washington, DC: GAO.

Ullman, F., Bruen, B., and Holahan, J. (1998). *The State Children's Health Insurance Program: A look at the numbers.* Washington, DC: Urban Institute.

Vargas, C. M., Crall, J. J., and Schneider, D. A. (1998). Sociodemographic distribution of pediatric dental caries. *Journal of the American Dental Association, 129*, 1229-1238.

Walcott-McQuigg, J. A. (1995). The relationship between stress and weight-control behavior in African-American women. *Journal of the National Medical Association, 87*, 427-432.

Waldman, H. B. (1998). More children unable to get dental care than any other single health service. *ASDC Journal of Dentistry for Children, 65*, 204-208.

Waldron, I., and Jacobs, J. A. (1989). Effects of labor force participation on women's health: New evidence from a longitudinal study. *Journal of Occupational Medicine, 30*, 977-983.

Wallace, D., and Wallace, R. (1998). Scales of geography, time, and population: The study of violence as a public health problem. *American Journal of Public Health, 88*, 1853-1958.

Ware, J. E., Kosinski, M., and Keller, S. D. (1996). A 12-item Short-Form Health Survey. *Medical Care, 34*, 220-233.

Wehler, C. A., Scott, R. I., Anderson, J. J., Summer, L., and Parker, L. (1995). *Community Childhood Hunger Identification Project: A survey of childhood hunger in the United States.* Washington, DC: Food Research and Action Center.

Weinreb, L., Goldberg, R., Bassuk, E., and Perloff, J. (1998). Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics, 102*, 554-562.

Weissman, J. S., and Epstein, A. M. (1994). *Falling through the safety net: Insurance status and access to health care.* Baltimore, MD: Johns Hopkins University Press.

Williams, D. R., and Collins, C. (1995). U.S. socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology, 21*, 349-386.

Wiseman, M. (1999). In the midst of reform: Wisconsin in 1997. *Focus, 20* (3), 15-22.

Wolfe, B. L., and Hill, S. C. (1995). The effect of health on the work effort of single mothers. *Journal of Human Resources, 30*, 42-62.

Yelin, E., and Trupin, L. (1999). Who succeeds and who fails in the new world of work? San Francisco: University of California-San Francisco, Institute for Health and Policy Studies.

Yen, I. H., and Kaplan, G. A. (1998). Poverty area residence and changes in physical activity level: Evidence from the Alameda County Study. *American Journal of Public Health, 88*, 1709-1712.

Yen, I. H., and Kaplan, G. A. (1999). Poverty area residence and changes in depression and perceived health status: Evidence from the Alameda County Study. *International Journal of Epidemiology, 28*, 90-94.

Zedlewski, S. R. (1999). Work activity and obstacles to work among TANF recipients. *Assessing the New Federalism: Issues and Options for States*, Series B, No. B-2. Washington, DC: Urban Institute.

Zedlewski, S. R. and Brauner, S. (1999). Declines in food stamp and welfare participation: Is there a connection? Washington, DC: Urban Institute.

Zimmermann, W., and Tumlin, K. C. (1999). Patchwork policies: State assistance for immigrants under welfare reform. *Assessing the New Federalism: Issues and Options for States*, Occasional Paper No. 24. Washington, DC: Urban Institute.

Zlotnick, C. (1987). Pediculosis corporis and the homeless. *Journal of Community Health Nursing, 4*, 43-48.

Recent Publications on MDRC Projects

Note: For works not published by MDRC, the publisher's name is shown in parentheses. A complete publications list is available from MDRC and on its Web site (www.mdrc.org), which also contains copies of MDRC's publications.

Reforming Welfare and Making Work Pay

Next Generation Project

A collaboration among researchers at MDRC and several leading research institutions focused on studying the effects of welfare, antipoverty, and employment policies on children and families.

How Welfare and Work Policies Affect Children: A Synthesis of Research. 2001. Pamela Morris, Aletha Huston, Greg Duncan, Danielle Crosby, Johannes Bos.

How Welfare and Work Policies Affect Employment and Income: A Synthesis of Research. 2001. Dan Bloom, Charles Michalopoulos.

ReWORKing Welfare: Technical Assistance for States and Localities

A multifaceted effort to assist states and localities in designing and implementing their welfare reform programs. The project includes a series of "how-to" guides, conferences, briefings, and customized, in-depth technical assistance.

After AFDC: Welfare-to-Work Choices and Challenges for States. 1997. Dan Bloom.

Changing to a Work First Strategy: Lessons from Los Angeles County's GAIN Program for Welfare Recipients. 1997. Evan Weissman.

Work First: How to Implement an Employment-Focused Approach to Welfare Reform. 1997. Amy Brown.

Business Partnerships: How to Involve Employers in Welfare Reform. 1998. Amy Brown, Maria Buck, Erik Skinner.

Learnfare: How to Implement a Mandatory Stay-in-School Program for Teenage Parents on Welfare. 1998. David Long, Johannes Bos.

Promoting Participation: How to Increase Involvement in Welfare-to-Work Activities. 1999. Gayle Hamilton, Susan Scrivener.

Encouraging Work, Reducing Poverty: The Impact of Work Incentive Programs. 2000. Gordon Berlin.

Steady Work and Better Jobs: How to Help Low-Income Parents Sustain Employment and Advance in the Workforce. 2000. Julie Strawn, Karin Martinson.

Beyond Work First: How to Help Hard-to-Employ Individuals Get Jobs and Succeed in the Workforce. 2001. Amy Brown.

Project on Devolution and Urban Change

A multi-year study in four major urban counties — Cuyahoga County, Ohio (which includes the city of Cleveland), Los Angeles, Miami-Dade, and Philadelphia — that examines how welfare reforms are being implemented and affect poor people, their neighborhoods, and the institutions that serve them.

Big Cities and Welfare Reform: Early Implementation and Ethnographic Findings from the Project on Devolution and Urban Change. 1999. Janet Quint, Kathryn Edin, Maria Buck, Barbara Fink, Yolanda Padilla, Olis Simmons-Hewitt, Mary Valmont.

Food Security and Hunger in Poor, Mother-Headed Families in Four U.S. Cities. 2000. Denise Polit, Andrew London, John Martinez.

Assessing the Impact of Welfare Reform on Urban Communities: The Urban Change Project and Methodological Considerations. 2000. Charles Michalopoulos, Johannes Bos, Robert Lalonde, Nandita Verma.

Post-TANF Food Stamp and Medicaid Benefits: Factors That Aid or Impede Their Receipt. 2001. Janet Quint, Rebecca Widom.

Social Service Organizations and Welfare Reform. 2001. Barbara Fink, Rebecca Widom.

The Health of Poor Urban Women: Findings from the Project on Devolution and Urban Change. 2001. Denise Polit, Andrew London, John Martinez.

Time Limits

Florida's Family Transition Program

An evaluation of Florida's initial time-limited welfare program, which includes services, requirements, and financial work incentives intended to reduce long-term welfare receipt and help welfare recipients find and keep jobs.

The Family Transition Program: An Early Implementation Report on Florida's Time-Limited Welfare Initiative. 1995. Dan Bloom.

The Family Transition Program: Implementation and Early Impacts of Florida's Initial Time-Limited Welfare Program. 1997. Dan Bloom, James Kemple, Robin Rogers-Dillon.

The Family Transition Program: Implementation and Interim Impacts of Florida's Initial Time-Limited Welfare Program. 1998. Dan Bloom, Mary Farrell, James Kemple, Nandita Verma.

The Family Transition Program: Implementation and Three-Year Impacts of Florida's Initial Time-Limited Welfare Program. 1999. Dan Bloom, Mary Farrell, James Kemple, Nandita Verma.

The Family Transition Program: Final Report on Florida's Initial Time-Limited Welfare Program. 2000. Dan Bloom, James Kemple, Pamela Morris, Susan Scrivener, Nandita Verma, Richard Hendra.

Cross-State Study of Time-Limited Welfare

An examination of the implementation of some of the first state-initiated time-limited welfare programs.

Implementing Time-Limited Welfare: Early Experiences in Three States. 1995. Dan Bloom, David Butler.

The View from the Field: As Time Limits Approach, Welfare Recipients and Staff Talk About Their Attitudes and Expectations. 1997. Amy Brown, Dan Bloom, David Butler.

Welfare Time Limits: An Interim Report Card. 1999. Dan Bloom.

Connecticut's Jobs First Program

An evaluation of Connecticut's statewide time-limited welfare program, which includes financial work incentives and requirements to participate in employment-related services aimed at rapid job placement. This study provides some of the earliest information on the effects of time limits in major urban areas.

Early Data on the Implementation of Connecticut's Jobs First Program. 1997. Dan Bloom, Mary Andes.

Jobs First: Early Implementation of Connecticut's Welfare Reform Initiative. 1998. Dan Bloom, Mary Andes, Claudia Nicholson.

Connecticut Post-Time Limit Tracking Study: Three-Month Survey Results. 1998. Jo Anna Hunter-Manns, Dan Bloom, Richard Hendra, Johanna Walter.

Connecticut Post-Time Limit Tracking Study: Six-Month Survey Results. 1999. Jo Anna Hunter-Manns, Dan Bloom.

Jobs First: Implementation and Early Impacts of Connecticut's Welfare Reform Initiative. 2000. Dan Bloom, Laura Melton, Charles Michalopoulos, Susan Scrivener, Johanna Walter.

Vermont's Welfare Restructuring Project

An evaluation of Vermont's statewide welfare reform program, which includes a work requirement after a certain period of welfare receipt, and financial work incentives.

WRP: Implementation and Early Impacts of Vermont's Welfare Restructuring Project. 1998. Dan Bloom, Charles Michalopoulos, Johanna Walter, Patricia Auspos.

Forty-Two Month Impacts of Vermont's Welfare Restructuring Project. 1999. Richard Hendra, Charles Michalopoulos.

WRP: Key Findings from the Forty-Two-Month Client Survey. 2000. Dan Bloom, Richard Hendra, Charles Michalopoulos.

Financial Incentives

Encouraging Work, Reducing Poverty: The Impact of Work Incentive Programs. 2000. Gordon Berlin.

Minnesota Family Investment Program

An evaluation of Minnesota's pilot welfare reform initiative, which aims to encourage work, alleviate poverty, and reduce welfare dependence.

MFIP: An Early Report on Minnesota's Approach to Welfare Reform. 1995. Virginia Knox, Amy Brown, Winston Lin.

Making Welfare Work and Work Pay: Implementation and 18-Month Impacts of the Minnesota Family Investment Program. 1997. Cynthia Miller, Virginia Knox, Patricia Auspos, Jo Anna Hunter-Manns, Alan Orenstein.

Reforming Welfare and Rewarding Work: Final Report on the Minnesota Family Investment Program. 2000:

Volume 1: Effects on Adults. Cynthia Miller, Virginia Knox, Lisa Gennetian, Martey Dodoo, Jo Anna Hunter, Cindy Redcross.

Volume 2: Effects on Children. Lisa Gennetian, Cynthia Miller.

Reforming Welfare and Rewarding Work: A Summary of the Final Report on the Minnesota Family Investment Program. 2000. Virginia Knox, Cynthia Miller, Lisa Gennetian.

Final Report on the Implementation and Impacts of the Minnesota Family Investment Program in Ramsey County. 2000. Patricia Auspos, Cynthia Miller, Jo Anna Hunter.

New Hope Project

A test of a community-based, work-focused antipoverty program and welfare alternative operating in Milwaukee.

The New Hope Offer: Participants in the New Hope Demonstration Discuss Work, Family, and Self-Sufficiency. 1996. Dudley Benoit.

Creating New Hope: Implementation of a Program to Reduce Poverty and Reform Welfare. 1997. Thomas

Brock, Fred Doolittle, Veronica Fellerath, Michael Wiseman.

Who Got New Hope? 1997. Michael Wiseman.

An Early Look at Community Service Jobs in the New Hope Demonstration. 1998. Susan Poglinco, Julian Brash, Robert Granger.

New Hope for People with Low Incomes: Two-Year Results of a Program to Reduce Poverty and Reform Welfare. 1999. Johannes Bos, Aletha Huston, Robert Granger, Greg Duncan, Thomas Brock, Vonnie McLoyd.

Canada's Self-Sufficiency Project

A test of the effectiveness of a temporary earnings supplement on the employment and welfare receipt of public assistance recipients. Reports on the Self-Sufficiency Project are available from: Social Research and Demonstration Corporation (SRDC), 275 Slater St., Suite 900, Ottawa, Ontario K1P 5H9, Canada. Tel.: 613-237-4311; Fax: 613-237-5045. In the United States, the reports are also available from MDRC.

Creating an Alternative to Welfare: First-Year Findings on the Implementation, Welfare Impacts, and Costs of the Self-Sufficiency Project (Social Research and Demonstration Corporation [SRDC]). 1995. Tod Mijanovich, David Long.

The Struggle for Self-Sufficiency: Participants in the Self-Sufficiency Project Talk About Work, Welfare, and Their Futures (SRDC). 1995. Wendy Bancroft, Sheila Currie Vernon.

Do Financial Incentives Encourage Welfare Recipients to Work? Initial 18-Month Findings from the Self-Sufficiency Project (SRDC). 1996. David Card, Philip Robins.

When Work Pays Better Than Welfare: A Summary of the Self-Sufficiency Project's Implementation, Focus Group, and Initial 18-Month Impact Reports (SRDC). 1996.

How Important Are "Entry Effects" in Financial Incentive Programs for Welfare Recipients? Experimental Evidence from the Self-Sufficiency Project (SRDC). 1997. David Card, Philip Robins, Winston Lin.

Do Work Incentives Have Unintended Consequences? Measuring "Entry Effects" in the Self-Sufficiency Project (SRDC). 1998. Gordon Berlin, Wendy Bancroft, David Card, Winston Lin, Philip Robins.

When Financial Incentives Encourage Work: Complete 18-Month Findings from the Self-Sufficiency Project (SRDC). 1998. Winston Lin, Philip Robins, David Card, Kristen Harknett, Susanna Lui-Gurr.

Does SSP Plus Increase Employment? The Effect of Adding Services to the Self-Sufficiency Project's Financial Incentives (SRDC). 1999. Gail Quets, Philip Robins, Elsie Pan, Charles Michalopoulos, David Card.

When Financial Work Incentives Pay for Themselves: Early Findings from the Self-Sufficiency Project's Applicant Study (SRDC). 1999. Charles Michalopoulos, Philip Robins, David Card.

Financial Work Incentive on Employment and Income (SRDC). 2000. Charles Michalopoulos, David Card, Lisa Gennetian, Kristen Harknett, Philip K. Robins.

The Self-Sufficiency Project at 36 Months: Effects on Children of a Program That Increased Parental Employment and Income (SRDC). 2000. Pamela Morris, Charles Michalopoulos.

Mandatory Welfare Employment Programs

National Evaluation of Welfare-to-Work Strategies

Conceived and sponsored by the U.S. Department of Health and Human Services, with support from the U.S. Department of Education, this is the largest-scale evaluation ever conducted of different strategies for moving people from welfare to employment.

Adult Education for People on AFDC: A Synthesis of Research (U.S. Department of Education [ED]/U.S. Department of Health and Human Services [HHS]). 1995. Edward Pauly.

Early Findings on Program Impacts in Three Sites (HHS/ED). 1995. Stephen Freedman, Daniel Friedlander.

Five Years After: The Long-Term Effects of Welfare-to-Work Programs (Russell Sage Foundation). 1995. Daniel Friedlander, Gary Burtless.

Monthly Participation Rates in Three Sites and Factors Affecting Participation Levels in Welfare-to-Work Programs (HHS/ED). 1995. Gayle Hamilton.

Changing to a Work First Strategy: Lessons from Los Angeles County's GAIN Program for Welfare Recipients. 1997. Evan Weissman.

Evaluating Two Welfare-to-Work Program Approaches: Two-Year Findings on the Labor Force Attachment and Human Capital Development Programs in Three Sites (HHS/ED). 1997. Gayle Hamilton, Thomas Brock, Mary Farrell, Daniel Friedlander, Kristen Harknett.

Work First: How to Implement an Employment-Focused Approach to Welfare Reform. 1997. Amy Brown.

Implementation, Participation Patterns, Costs, and Two-Year Impacts of the Portland (Oregon) Welfare-to-Work Program (HHS/ED). 1998. Susan Scrivener, Gayle Hamilton, Mary Farrell, Stephen Freedman, Daniel Friedlander, Marisa Mitchell, Jodi Nudelman, Christine Schwartz.

Do Mandatory Welfare-to-Work Programs Affect the Well-Being of Children? A Synthesis of Child Research Conducted as Part of the National Evaluation of Welfare-to-Work Strategies (HHS/ED). 2000. Gayle Hamilton.

Evaluating Alternative Welfare-to-Work Approaches: Two-Year Impacts for Eleven Programs (HHS/ED). 2000. Stephen Freedman, Daniel Friedlander, Gayle Hamilton, JoAnn Rock, Marisa Mitchell, Jodi Nudelman, Amanda Schweder, Laura Storto.

Impacts on Young Children and Their Families Two Years After Enrollment: Findings from the Child Outcomes Study (HHS/ED). 2000. Sharon McGroder, Martha Zaslow, Kristin Moore, Suzanne LeMenestrel.

What Works Best for Whom: Impacts of 20 Welfare-to-Work Programs by Subgroup (HHS/ED). 2000. Charles Michalopoulos, Christine Schwartz.

Four Year Impacts of Ten Programs on Employment stability and Earnings Growth. (HHS/ED). 2000. Stephen Freedman. Available from the U.S. Department of Health and Human Services and on www.mdrc.org.

The Experiences of Welfare Recipients Who Find Jobs (HHS/ED). 2000. Karin Martinson. Available from the U.S. Department of Health and Human Services and on www.mdrc.org.

Los Angeles's Jobs-First GAIN Program

An evaluation of Los Angeles's refocused GAIN (welfare-to-work) program, which emphasizes rapid employment. This is the first in-depth study of a full-scale "work first" program in one of the nation's largest urban areas.

Changing to a Work First Strategy: Lessons from Los Angeles County's GAIN Program for Welfare Recipients. 1997. Evan Weissman.

The Los Angeles Jobs-First GAIN Evaluation: Preliminary Findings on Participation Patterns and First-Year Impacts. 1998. Stephen Freedman, Marisa Mitchell, David Navarro.

The Los Angeles Jobs-First GAIN Evaluation: First-Year Findings on Participation Patterns and Impacts. 1999. Stephen Freedman, Marisa Mitchell, David Navarro.

The Los Angeles Jobs-First GAIN Evaluation: Final Report on a Work First Program in a Major Urban Center. 2000. Stephen Freedman, Jean Knab, Lisa Gennetian, David Navarro.

Teen Parents on Welfare

Teenage Parent Programs: A Synthesis of the Long-Term Effects of the New Chance Demonstration, Ohio's Learning, Earning, and Parenting (LEAP) Program, and the Teenage Parent Demonstration (TPD). 1998. Robert Granger, Rachel Cytron.

Ohio's LEAP Program

An evaluation of Ohio's Learning, Earning, and Parenting (LEAP) Program, which uses financial incentives to encourage teenage parents on welfare to stay in or return to school.

LEAP: Final Report on Ohio's Welfare Initiative to Improve School Attendance Among Teenage Parents. 1997. Johannes Bos, Veronica Fellerath.

New Chance Demonstration

A test of a comprehensive program of services that seeks to improve the economic status and general well-being of a group of highly disadvantaged young women and their children.

New Chance: Final Report on a Comprehensive Program for Young Mothers in Poverty and Their Children. 1997. Janet Quint, Johannes Bos, Denise Polit.

Parenting Behavior in a Sample of Young Mothers in Poverty: Results of the New Chance Observational Study. 1998. Martha Zaslow, Carolyn Eldred, editors.

Focusing on Fathers

Parents' Fair Share Demonstration

A demonstration for unemployed noncustodial parents (usually fathers) of children on welfare. PFS aims to improve the men's employment and earnings, reduce child poverty by increasing child support payments, and assist the fathers in playing a broader constructive role in their children's lives.

Low-Income Parents and the Parents' Fair Share Demonstration. 1996. Earl Johnson, Fred Doolittle.

Working with Low-Income Cases: Lessons for the Child Support Enforcement System from Parents' Fair Share. 1998. Fred Doolittle, Suzanne Lynn.

Building Opportunities, Enforcing Obligations: Implementation and Interim Impacts of Parents' Fair Share. 1998. Fred Doolittle, Virginia Knox, Cynthia Miller, Sharon Rowser.

Fathers' Fair Share: Helping Poor Men Manage Child Support and Fatherhood (Russell Sage Foundation). 1999. Earl Johnson, Ann Levine, Fred Doolittle.

Parenting and Providing: The Impact of Parents' Fair Share on Paternal Involvement. 2000. Virginia Knox, Cindy Redcross.

Working and Earning: The Impact of Parents' Fair Share on Low-Income Fathers' Employment. 2000. John M. Martinez, Cynthia Miller.

The Responsible Fatherhood Curriculum. 2000. Eileen Hayes, with Kay Sherwood.

Other

Can They All Work? A Study of the Employment Potential of Welfare Recipients in a Welfare-to-Work Program. 1995. James Riccio, Stephen Freedman.

Florida's Project Independence: Benefits, Costs, and Two-Year Impacts of Florida's JOBS Program. 1995. James Kemple, Daniel Friedlander, Veronica Fellerath.

From Welfare to Work Among Lone Parents in Britain: Lessons for America. 1996. James Riccio.

Education Reform

Career Academies

The largest and most comprehensive evaluation of a school-to-work initiative, this study examines a promising approach to high school restructuring and the school-to-work transition.

Career Academies: Early Implementation Lessons from a 10-Site Evaluation. 1996. James Kemple, JoAnn Leah Rock.

Career Academies: Communities of Support for Students and Teachers — Emerging Findings from a 10-Site Evaluation. 1997. James Kemple.

Career Academies: Building Career Awareness and Work-Based Learning Activities Through Employer Partnerships. 1999. James Kemple, Susan Poglinco, Jason Snipes.

Career Academies: Impacts on Students' Engagement and Performance in High School. 2000. James Kemple, Jason Snipes.

Project GRAD

This evaluation examines Project GRAD, an education initiative targeted at urban schools and combining a number of proven or promising reforms.

Building the Foundation for Improved Student Performance: The Pre-Curricular Phase of Project GRAD Newark. 2000. Sandra Ham, Fred C. Doolittle, Glee Ivory Holton.

LILAA Initiative

This study of the Literacy in Libraries Across America (LILAA) initiative explores the efforts of five adult literacy programs in public libraries to improve learner persistence.

So I Made Up My Mind: Introducing a Study of Adult Learner Persistence in Library Literacy Programs. 2000. John T. Comings, Sondra Cuban.

Project Transition

A demonstration program that tested a combination of school-based strategies to facilitate students' transition from middle school to high school.

Project Transition: Testing an Intervention to Help High School Freshmen Succeed. 1999. Janet Quint, Cynthia Miller, Jennifer Pastor, Rachel Cytron.

Equity 2000

Equity 2000 is a nationwide initiative sponsored by the College Board to improve low-income students' access to college. The MDRC paper examines the implementation of Equity 2000 in Milwaukee Public Schools.

Getting to the Right Algebra: The Equity 2000 Initiative in Milwaukee Public Schools. 1999. Sandra Ham, Erica Walker.

School-to-Work Project

A study of innovative programs that help students make the transition from school to work or careers.

Home-Grown Lessons: Innovative Programs Linking School and Work (Jossey-Bass Publishers). 1995. Edward Pauly, Hilary Kopp, Joshua Haimson.

Home-Grown Progress: The Evolution of Innovative School-to-Work Programs. 1997. Rachel Pedraza, Edward Pauly, Hilary Kopp.

Employment and Community Initiatives

Connections to Work Project

A study of local efforts to increase competition in the choice of providers of employment services for welfare recipients and other low-income populations. The project also provides assistance to cutting-edge local initiatives aimed at helping such people access and secure jobs.

Tulsa's IndEx Program: A Business-Led Initiative for Welfare Reform and Economic Development. 1997. Maria Buck.

Washington Works: Sustaining a Vision of Welfare Reform Based on Personal Change, Work Preparation, and Employer Involvement. 1998. Susan Gooden.

Cost Analysis Step by Step: A How-to Guide for Planners and Providers of Welfare-to-Work and Other Employment and Training Programs. 1998. David Greenberg, Ute Appenzeller.

Designing and Administering a Wage-Paying Community Service Employment Program Under TANF: Some Considerations and Choices. 1999. Kay Sherwood.

San Francisco Works: Toward an Employer-Led Approach to Welfare Reform and Workforce Development. 2000. Steven Bliss.

Jobs-Plus Initiative

A multi-site effort to greatly increase employment among public housing residents.

A Research Framework for Evaluating Jobs-Plus, a Saturation and Place-Based Employment Initiative for Public Housing Residents. 1998. James Riccio.

Mobilizing Public Housing Communities for Work: Origins and Early Accomplishments of the Jobs-Plus Demonstration. 1999. James Riccio.

Building a Convincing Test of a Public Housing Employment Program Using Non-Experimental Methods: Planning for the Jobs-Plus Demonstration. 1999. Howard Bloom.

Jobs-Plus Site-by-Site: An Early Look at Program Implementation. 2000. Edited by Susan Philipson Bloom with Susan Blank.

Section 3 Public Housing Study

An examination of the effectiveness of Section 3 of the 1968 Housing and Urban Development Act in affording employment opportunities for public housing residents.

Lessons from the Field on the Implementation of Section 3 (U.S. Department of Housing and Urban Development). 1996. Maxine Bailey, Suzanne Lynn.

Canada's Earnings Supplement Project

A test of an innovative financial incentive intended to expedite the reemployment of displaced workers and encourage full-year work by seasonal or part-year workers, thereby also reducing receipt of Unemployment Insurance.

Implementing the Earnings Supplement Project: A Test of a Re-employment Incentive (Social Research and Demonstration Corporation). 1997. Howard Bloom, Barbara Fink, Susanna Lui-Gurr, Wendy Bancroft, Doug Tattrie.

Testing a Re-employment Incentive for Displaced Workers: The Earnings Supplement Project. 1999. Howard Bloom, Saul Schwartz, Susanna Lui-Gurr, Suk-Won Lee.

MDRC Working Papers on Research Methodology

A new series of papers that explore alternative methods of examining the implementation and impacts of programs and policies.

Building a Convincing Test of a Public Housing Employment Program Using Non-Experimental Methods: Planning for the Jobs-Plus Demonstration. 1999. Howard Bloom.

Estimating Program Impacts on Student Achievement Using "Short" Interrupted Time Series. 1999. Howard Bloom.

Using Cluster Random Assignment to Measure Program Impacts: Statistical Implications for the Evaluation of Education Programs. 1999. Howard Bloom, Johannes Bos, Suk-Won Lee.

About MDRC

The Manpower Demonstration Research Corporation (MDRC) is a nonprofit, nonpartisan social policy research organization. We are dedicated to learning what works to improve the well-being of low-income people. Through our research and the active communication of our findings, we seek to enhance the effectiveness of social policies and programs. MDRC was founded in 1974 and is located in New York City and San Francisco.

MDRC's current projects focus on welfare and economic security, education, and employment and community initiatives. Complementing our evaluations of a wide range of welfare reforms are new studies of supports for the working poor and emerging analyses of how programs affect children's development and their families' well-being. In the field of education, we are testing reforms aimed at improving the performance of public schools, especially in urban areas. Finally, our community projects are using innovative approaches to increase employment in low-income neighborhoods.

Our projects are a mix of demonstrations — field tests of promising program models — and evaluations of government and community initiatives, and we employ a wide range of methods such as large-scale studies to determine a program's effects, surveys, case studies, and ethnographies of individuals and families. We share the findings and lessons from our work — including best practices for program operators — with a broad audience within the policy and practitioner community, as well as the general public and the media.

Over the past quarter century, MDRC has worked in almost every state, all of the nation's largest cities, and Canada. We conduct our projects in partnership with state and local governments, the federal government, public school systems, community organizations, and numerous private philanthropies.

MDRC

16 East 34 Street
New York, New York 10016
(212) 532-3200

www.mdrc.org

88 Kearny Street, Suite 1800
San Francisco, California 94108
(415) 781-3800

BEST COPY AVAILABLE